336 Armour Road
Peterborough, Ontario
K9H 1Y6

Phone: 705-743-8085
Fax: 705-743-7268
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Date______________________

Orthodontic Insurance Information

Many people have personal or company insurance plans which cover part of their orthodontic treatment. Terms of orthodontic insurance coverage vary among insurance companies and individual policies.

Please bring this completed form, and your current insurance card to your consultation appointment. We will use this information to complete the necessary forms you will need in order to receive the reimbursement to which you are entitled under your policy.

Patient Information

Patient Name: ____
(Dr. Mr. Mrs. Ms. Miss) First Last

Birthdate: ____MM / DD / YY____ Age: ________ School: ______________________

Insurance Particulars

Do you have orthodontic coverage? ☐ Yes ☐ No ☐ Unsure

Primary Insurance

Group/Plan #: ______________________

ID #: ______________________

Subscriber's Name: ______________________

Subscriber's Birthday: __ MM / DD / YY __

Subscriber's Address: ______________________

____

Relationship to Patient: ______________________

Employer: ______________________

Insurance Company: ______________________

Secondary Insurance

Group/Plan #: ______________________

ID #: ______________________

Subscriber's Name: ______________________

Subscriber's Birthday: __ MM / DD / YY __

Subscriber's Address: ______________________

(If different than primary subscriber) ______________________

Relationship to Patient: ______________________

Employer: ______________________

Insurance Company: ______________________

If you wish to determine the specific details of your orthodontic coverage, please contact your insurance company and ask the following questions:

Primary Insurance

Total Orthodontic Benefit: ______________________

Is there an age limit on the policy? ☐ Yes ☐ No

If so, limited to age? ____________

Is this a lifetime or calendar year benefit? ____________

Benefits are payable at what percent? ____________

Secondary Insurance

Total Orthodontic Benefit: ______________________

Is there an age limit on the policy? ☐ Yes ☐ No

If so, limited to age? ____________

Is this a lifetime or calendar year benefit? ____________

Benefits are payable at what percent? ____________