



Scanned: _____

Patient Name: _____

Patient DOB: _____

Consultation Date: _____

INSURANCE GUIDELINES

Is Dr. Theresa Shaver a Participating Orthodontic Provider? Yes or No

PRIMARY DENTAL INSURANCE

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone #: _____ Group#: _____

Orthodontic Lifetime Maximum: _____ %, up to \$ _____

Insured's Name: _____

Insured's DOB: _____ Insured's Employer: _____

Insured's SSN: _____ Subscriber ID#: _____

Relationship to Patient: _____

SECONDARY DENTAL INSURANCE

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone #: _____ Group#: _____

Orthodontic Lifetime Maximum: _____ %, up to \$ _____

Insured's Name: _____

Insured's DOB: _____ Insured's Employer: _____

Insured's SSN: _____ Subscriber ID#: _____

Relationship to Patient: _____

Payments will be made: Monthly _____ Quarterly _____ Other _____

Age Limit: _____ Deductible: _____