ORTHODONTIC INSURANCE INFORMATION

NAME OF PATIENT ____

NAME OF SUBSCRIBER ____

EMPLOYER NAME____

DENTAL INSURANCE COMPANY__________________________________

POLICY NUMBER ____

SUBSCRIBER'S DATE OF BIRTH ____________SS# __________________

INSURANCE PHONE ____

MAILING ADDRESS ____

LIFETIME MAXIMUM ORTHODONTIC BENEFIT $____________________

AMOUNT OF BENEFIT REMAINING ______________________________

AGE LIMIT_________________ PERCENT COVERAGE_______________

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