San Ramon ORTHODONTICS

IMPORTANT

PLEASE COMPLETE THIS FORM PRIOR TO YOUR APPOINTMENT

If this form is not complete, we cannot give you an accurate estimate of fees

Patient Name	
Insured (this is the employee) Name	
Insured (employee) SS# or ID#	
Insured (employee) Birthday	
Employer Name	
Group Number	
Insurance Company Name	

Policy Benefits are _____% to a lifetime maximum of $_____

PLEASE COMPLETE THIS PART IF YOU HAVE TWO OR MORE INSURANCE CARRIERS

Secondary carrier (the company that will pay after the prime carrier's company pays):

The primary Carrier is determined by which parent's birth date is earlier in the year. In case of divorced parents, it is usually the custodial parent that is considered primer carrier.

Employee Name	
Employee SS# or ID#	
Employee Date of Birth	
Employer Name	
Group Number	
Insurance Company Name	

Policy Benefits are _____% to a lifetime maximum of $_____

We are more than happy to help you with obtaining your insurance benefits by submitting claims on your behalf and accepting assignment of benefits. However, please remember, the contract for orthodontic treatment is with you, not with the insurance company. If insurance payment is denied, cancelled, or not paid, you are responsible for full payment of this account. I hereby authorize release of any information related to claims and authorize payment directly to Dr Karkhanechi, DDS.

Signature: _____

Date: _____