



Account & Insurance Information

Name: _____

Primary Insurance

Policy Owner: _____ Relation: _____

Birthdate: _____ SS#: _____

Home #: _____ Cell #: _____

Employer: _____

Insurance Company: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Phone # for Insurance Claims: _____ ID #: _____

Group #: _____ Plan #: _____

Secondary Insurance

Policy Owner: _____ Relation: _____

Birthdate: _____ SS#: _____

Home #: _____ Cell #: _____

Employer: _____

Insurance Company: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Phone # for Insurance Claims: _____ ID #: _____

Group #: _____ Plan #: _____

Acknowledgement

By signing below, you consent you permission for Nathan Thomas Orthodontics to submit any insurance claims on your behalf and also accept assignment of benefits otherwise payable to the insured.

Signature: _____ Date: _____