STONY BROOK ORTHODONTICS

Insurance Information: ***Please present insurance card and license if applicable***

Dental Insurance: _____Group Number: _____ Employer: _____

Policy Holders Name: _____Date of Birth: _____

Policy Holder ID/Social Security number: _____

Policy Holder's Address (if different):_____

Patient's Relationship to Policy Holder: Self Spouse Dependent Other

Do you have another dental coverage: Yes No

Dental Insurance: _____ Group Number: _____ Employer: _____

Policy Holder Name: _____ Date of Birth: _____

Policy Holder ID/Social Security number: _____

Policy Holder Address (if different): _____

Patient's Relationship to Policy Holder: Self Spouse Dependent Other

Authorization for Insurance Claim Submission:

I hereby authorize payment and direct payment of the dental benefits otherwise payable to me, directly to Stony Brook Orthodontics.

Signature of Insured Person: _____Date:_____