SHANNON
ORTHODONTICS
for children and adults

Dental Insurance Information and Release

❖In order to obtain full benefit details we recommend calling your insurance company directly.❖

Patient's Legal Name: _____

Patient's Date of Birth: ____/____/_____

Is the Patient a Full Time Student? ☐ **Yes** ☐ **No**

Name of Dental Insurance: _____

Dental Insurance Phone #: _____

Group #: _____

Name of Primary Policy Holder: _____

Relationship to Patient: _____

Employer: _____

Member ID: _____
(if not known, please provide SSN:)

Social Security #: _____

Date of Birth: ___/___/_____

Authorization and Release:

I authorize the release of information necessary to process the dental insurance claims. I authorize dental insurance benefit payments to be made directly to Shannon Orthodontics.

_____ _____
Signature Date

_____
Please Print Signature

For Office Use:

LTM _____ Adult _____

Avail _____ Age Limit _____

Pays @_____ Payer ID _____

Ded _____ PPO _____

Wtg Per_____ Initial _____