Name of Insured:_____

Address of Insured:_____

Contact Phone # of Insured:_____

Insured's Employer:_____

Insured's SS#:_____ Date of Birth:_____

Insured's ID# (from ins. card):_____

Name and Address of Insurance Company:_____

_____

_____

Insurance Group Name:_____ Group Number:_____

Ins. Co. Toll-free Phone #:_____

I authorize release of any information relating to any claims, and I authorize payment of orthodontic benefits directly to Midwest Orthodontic Associates.

Signature: _____

I accept responsibility for 100% of the out-of-pocket orthodontic expenses, and I understand that Midwest Orthodontic Associates may use a credit reporting service to verify my credit status prior to setting a firm payment plan. I authorize Midwest Orthodontic Associates to proceed with the recommended orthodontic care.

Name of Responsible Party :_____

Address:_____

Signature: _____

SS#: _____ Date of Birth: _____

PLEASE NOTE THAT EACH SIGNATURE LINE MUST BE SIGNED IF THE PRECEDING INFORMATION APPLIES TO YOUR SITUATION. SOCIAL SECURITY NUMBER OR ID NUMBER AND DATE OF BIRTH ARE REQUIRED FOR INSURANCE SUBMISSION AND SOCIAL SECURITY NUMBER AND DATE OF BIRTH ARE REQUIRED FOR CREDIT REPORTING.