DENTAL INSURANCE AUTHORIZATION

I AUTHORIZE THE OFFICE OF *SPARKS FAMILY ORTHODONTICS* TO BILL MY INSURANCE COMPANY FOR ANY EXPENSES INCURRED FOR ORTHODONTIC TREATMENT AND FOR PAYMENT TO BE MADE DIRECTLY TO *SPARKS FAMILY ORTHODONTICS*. I ALSO GIVE AUTHORIZATION FOR THE OFFICE OF *SPARKS FAMILY ORTHODONTICS* TO RELEASE ANY NECESSARY INFORMATION TO MY INSURANCE COMPANY FOR THE PROCESSING OF ANY ORTHODONTIC CLAIM.

Please fill out completely so your insurance benefit can be quoted accurately

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FULL PATIENT NAME: _____

Primary Dental Insurance: _____ Group #: _____

Insurance Carrier Address: _____

Employer of Policy Holder: _____

Full Name of Policy Holder: _____

Policy Holder Address: _____

Birthday of Policy Holder: _____

ID#: _____ SS#: _____

Social Security # required for insurance billing

Secondary Dental Insurance: _____ Group #: _____

Insurance Carrier Address: _____

Employer of Policy Holder: _____

Full Name of Policy Holder: _____

Policy Holder Address: _____

Birthday of Policy Holder: _____

ID#: _____ SS#: _____

Social Security # required for insurance billing

SIGNATURE: _____ DATE: _____

(Authorization to bill your insurance)

Please provide insurance cards if available