MOURITSEN ORTHODONTICS

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FOR OFFICE USE ONLY

EFF. DATE:	
DEDUCTABLE:	
PAID @:	
AUTO:	
MONTHLY:	QTRLY:
BENEFITS:	
ANY USED:	
AGE LIMITS:	
NOTES:	

Please fill out this form in its entirety, we can not verify or accept insurance with any missing information.

Name of Patient: _____ **Date of birth:** _____

Insured's Information:
Name of Insured: _____ **Date of birth:** _____ **SSN:** _____
Employer Name: _____
Employer's Address: _____
Insurance Company: _____ **Phone number:** _____
Insurance Company Address: _____ **City:** _____**State:** _____ **Zip:** _____
Group number: _____ **ID#:** _____

If you have Secondary Insurance Coverage please complete:

Insured's Information:
Name of Insured: _____ **Date of birth:** _____ **SSN:** _____
Employer Name: _____
Employer's Address: _____
Insurance Company: _____ **Phone number:** _____
Insurance Company Address: _____ **City:** _____**State:** _____ **Zip:** _____
Group number: _____ **ID#:** _____

Please read and initial all highlighted areas below and return with your New Patient Form.

We are happy to file your first insurance claim for you at no additional charge however there will be a $35 fee if any additional filings are required during your treatment time. (This includes but is not limited to any insurance changes due to employment change or the changing of insurance companies by your employer). _____
If your insurance company has not paid within 90 days of the banding date (the date appliances/braces were placed) the entire insurance balance becomes the responsibility of the subscriber. _____
I have reviewed this claim and I authorize the release of any information related to this claim. _____

Signature of Patient (or Parent if patient is under 18): _____**Date:** _____

I hereby authorize all payments directly to David A. Mouritsen, D.D.S., M.S., PLLC

Signature of Insured: _____**Date:** _____