971 Hilltop Dr.
Weatherford, TX 76086

817.599.5084
www.GetBraces.BIZ

INSURANCE INFORMATION

Patient Name: _____ Date: _____

If insurance will be involved you will receive another form titled “Understanding Insurance”.

PRIMARY INSURANCE:

Name of Policy Holder: _____
Last First Middle

Name of Employer: _____

Address: _____
Street City State Zip

Name of Insurance Company: _____
Area Code + Phone

Address: _____
Street City State Zip

Group Number: _____ Insured Social Security Number: _____

Insured Date of Birth: _____ Insured Relationship to Patient: _____

****

SECONDARY INSURANCE: (if applicable)

Name of Policy Holder: _____
Last First Middle

Name of Employer: _____

Address: _____
Street City State Zip

Name of Insurance Company: _____
Area Code + Phone

Address: _____
Street City State Zip

Group Number: _____ Insured Social Security Number: _____

Insured Date of Birth: _____ Insured Relationship to Patient: _____