

Insurance Questionnaire

| | | |
|----------------------|-------------------|-------------------------|
| Patient | Date of Birth | Relation to Insured |
| Policy Holder | Date of Birth | Social or ALT.# on card |
| Employer | Ins. Company | Group Number |
| Phone # for Ins. Co. | Benefit Available | |

FOR OFFICE USE ONLY

| | |
|--------------------|----------------------|
| Benefit Used _____ | Covered at % _____ |
| Effective _____ | Waiting period _____ |
| COBenefit _____ | Work in Prog. _____ |
| Pays out _____ | Name of REP. _____ |
| DATE: _____ | VERIFIED BY _____ |

- **PLEASE COMPLETE IF PATIENT IS COVERED BY A SECOND PLAN**

| | | |
|----------------------|-------------------|-------------------------|
| Patient | Date of Birth | Relation to Insured |
| Policy Holder | Date of Birth | Social or ALT # on card |
| Employer | Ins. Company | Group Number |
| Phone # for Ins. Co. | Benefit Available | |

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| | |
|--------------------|-------------------|
| Benefit used _____ | Covered at |
| % _____ | |
| Effective _____ | Waiting |
| period _____ | |
| COBenefit _____ | Work in |
| Prog. _____ | |
| Pays out _____ | Name of |
| REP. _____ | |
| DATE _____ | VERIFIED BY _____ |

Reichheld Ting Orthodontics