

Dear \_\_\_\_\_,

In advance of your appointment with our office, please contact your dental insurance company to confirm and document the details of your orthodontic coverage. Please know that due to privacy protection, our office cannot contact your insurance company for this information. By having this information available at your first visit with our office, we will be able to provide you with more accurate information regarding the financial aspects of the orthodontic treatment. Please use this form to guide you in communicating with your insurer.

DENTAL PLAN #1

DENTAL PLAN #2

Insurance Company

Address for insurance company

Contact – full name of person  
you speak with at insurance  
company

Date of call

Time of call

Policy Holder

Policy Holder's Date of Birth

Group/Contract#

Certificate # and Dependent #

Orthodontic Lifetime maximum

Orthodontic reimbursement %

Is there a yearly maximum?

Is there a calendar year  
maximum?

Will they reimburse in full if  
treatment is paid in full?

Maximum Initial Fee %

Policy Age Limit

Orthodontic Age Limit

Please feel free to contact our office if you require assistance or further information.