RICK MARTIN, D.D.S. **CERTIFIED BY THE AMERICAN BOARD OF ORTHODONTICS**

PHONE (225) 925-9795 FAX (225) 925-9791 www.RickMartinOrthodontics.com

PLEASE PROVIDE THE FOLLOWING INSURANCE INFORMATION:

PATIENT NAME_____

DATE OF BIRTH _____

RELATIONSHIP TO INSURED: Self Spouse Child Other

INSURANCE COMPANY_____

ADDRESS_____

CITY/STATE/ZIP_____

PHONE_____

INSURED'S NAME_____

DATE OF BIRTH _____

ADDRESS_____

CITY/STATE/ZIP_____

SOCIAL SECURITY NUMBER_____

MEMBER ID_____

EMPLOYER_____

ADDRESS_____

CITY/STATER/ZIP_____

GROUP NUMBER_____

For office use only:

DATE VERIFIED_____ SPOKE WITH _____

EFFECTIVE DATE _____ WAITING PERIOD_____

COVERAGE _____ % UP TO _____ USED SO FAR _____

AGE LIMIT _____ EXTENSION FOR FULL TIME STUDENT? _____

NARRATIVE DESCRIPTION:

DIAGNOSIS CODE(S): _____ _____ _____ _____

PROCEDURE CODE: _____