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

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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: _______________