

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 _____

EMPLOYER _____

ADDRESS _____

CITY/STATER/ZIP _____

GROUP NUMBER _____

For office use only:

CODE: _____ NARRATIVE DESCRIPTION:

SPOKE WITH _____ DATE _____ TIME _____

EFFECTIVE DATE _____ WAITING PERIOD _____

COVERAGE _____ % UP TO _____ USED SO FAR _____

AGE LIMIT _____ EXTENSION FOR FULL TIME STUDENT? _____

Be sure to verify mailing address.