ROBERT W. BRUNO, DDS, PC
Orthodontics for Children & Adults

ORTHODONTIC INSURANCE FORM

In order to assist you in verifying your orthodontic insurance benefit, the following information *MUST* be filled out *COMPLETELY*:

PATIENT NAME_____ Date of Birth_____

Name of Policy Holder_____ Date of Birth_____

Address_____ Home phone_____

Social Security #_____ Alternate ID#_____

We MUST have your SSN or Alternate ID # to verify insurance. The insurance company will not provide us with benefits without it.

Employed by_____ Address_____

Insurance Company_____ Policy/Group#_____

Address of Insurance Company_____

Insurance Company Phone #_____

Is patient covered under another dental plan? If so, please complete the following information:

Name of Policy Holder_____ Date of Birth_____

Address_____ Home phone_____

Social Security #_____ Alternate ID#_____

We MUST have your SSN or Alternate ID # to verify insurance. The insurance company will not provide us with benefits without it.

Employed by_____ Address_____

Insurance Company_____ Policy/Group#_____

Address of Insurance Company_____

Insurance Company Phone #_____

I hereby authorize release of any information relating to this claim.

_____ _____

Signature Date

I hereby authorize payment of the insurance benefits directly to the above named orthodontists.

_____

Signature

Manhasset Orthodontics
900 Northern Blvd. Ste
240 Great Neck, NY 11021
516.365.2450 *Fax 516.482.6732

Woodside Orthodontics
68-03 41 Avenue
Woodside, NY 11377
718.565.7242 *Fax 718.565.7163