DOYLE
ORTHODONTICS

SEAN K. DOYLE, D.M.D.
INSURANCE INFORMATION SHEET

PATIENT'S NAME_____

DATE OF BIRTH_____SSN _____

RELATIONSHIP TO EMPLOYEE _____

INSURANCE COMPANY_____PHONE NUMBER _____

MAILING ADDRESS_____

_____

POLICY NUMBER _____

EMPLOYEE_____DOB_____

EMPLOYEE SSN#_____EMPLOYER _____

ADDRESS _____

_____

We file our Insurance electronically. The above information must be completed before we can process your claims. Thank you for your help.

I authorize Doyle Orthodontics to release any information requested with regard to this claim and the expense.

I authorize payment of benefits directly to Doyle Orthodontics

PLEASE SIGN BELOW

X_____ DATE _____

_____OFFICE USE BELOW THIS LINE _____

YEARLY DEDUCTIBLE_____ LIFETIME MAX_____ % PAID _____

AGE LIMIT _____ WAITING PERIOD _____ ORTHO USED _____

INSURANCE PAYMENT: MONTHLY QUARTERLY AUTO

Member
American Association of
Orthodontists
TM