MAXFIELD ORTHODONTICS

Person Responsible for Payment

Name ____

Relationship to Patient ☐ Self ☐ Spouse ☐ Mom ☐ Dad ☐ Step-mom ☐ Step-dad ☐ Other ______________

Home Address ______________________ City, State, ZIP ______________________

Home Phone ______________ Cell Phone ______________ Work Phone ______________

Email Address ______________________ Preferred method of contact ☐ Cell ☐ Home ☐ Work ☐ Email

Primary Insurance

Subscriber Name ______________ Subscriber Birth Date ______________ Subscriber Phone ______________

Relationship to Patient ☐ Self ☐ Spouse ☐ Mom ☐ Dad ☐ Step-mom ☐ Step-dad ☐ Other ______________

Subscriber Email ______________________ Subscriber Social Security # ______________________

Subscriber Home Address ______________________ City, State, ZIP ______________________

Subscriber ID # ______________________ Subscriber Employer ______________________

Insurance Name ______________________ Insurance Phone ______________________

Insurance Address ______________________ City, State, ZIP ______________________

Secondary Insurance

Subscriber Name ______________ Subscriber Birth Date ______________ Subscriber Phone ______________

Relationship to Patient ☐ Self ☐ Spouse ☐ Mom ☐ Dad ☐ Step-mom ☐ Step-dad ☐ Other ______________

Subscriber Email ______________________ Subscriber Social Security # ______________________

Subscriber Home Address ______________________ City, State, ZIP ______________________

Subscriber ID # ______________________ Subscriber Employer ______________________

Insurance Name ______________________ Insurance Phone ______________________

Insurance Address ______________________ City, State, ZIP ______________________

Signature

I understand that the information that I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in medical status.

I hereby authorize release of any information related to insurance claims. I consent to examination by the doctor and I authorize payment of any insurance benefits to the office.

Signature ________________________________ Date ______________