In an effort to assist you in receiving the greatest benefit from your orthodontic insurance, we ask you to update your insurance information by filling out this form as completely as possible. Thank you for your cooperation.

DIABLO
ORTHODONTIC SPECIALISTS

Date . . . . . .

PATIENT'S PRIMARY INSURANCE INFORMATION UPDATE

Patient's Name . . . . . Birth Date . . . . . Relationship to Insured . . . . . .

Insured Name . . . . . Birth Date . . . . . Social Security Number . . . . . .

Employer . . . . . .

Employer's Address . . . . . .

Insurance Co. Name . . . . . Policy or Group No. . . . . .

Insurance Co. Address . . . . . .

Insurance Co. Telephone *(800 No. if available)* . . . . . .

PLEASE COMPLETE THE FOLLOWING INFORMATION IF THE PATIENT IS COVERED BY A SECOND INSURANCE POLICY.

PATIENT'S SECONDARY INSURANCE INFORMATION UPDATE

Insured Name . . . . . Birth Date . . . . . Social Security Number . . . . . .

Patient Relationship to the Insured . . . . . .

Employer . . . . . .

Employer's Address . . . . . .

Insurance Co. Name . . . . . Policy or Group No. . . . . .

Insurance Co. Address . . . . . .

Insurance Co. Telephone *(800 No. if available)* . . . . . .

RELEASE AND ASSIGNMENT

Patient's Name . . . . . .

I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION INCLUDING THE DIAGNOSIS AND THE RECORDS OF ANY TREATMENT OR EXAMINATIONS RENDERED, TO MY INSURANCE COMPANY OR COMPANIES.

THIS RELEASE IS SOLELY FOR THE PURPOSE OF FACILITATING THE BILLING AND REIMBURSEMENT DIRECTLY TO THE DOCTOR, OF INSURANCE BENEFITS UNDER WHICH I AM ENTITLED.

Signature . . . . . Print your Name . . . . . .

Signature . . . . . Print your Name . . . . . .