INSURANCE AUTHORIZATION

I AUTHORIZE THE OFFICE OF *SPARKS FAMILY ORTHODONTICS* TO BILL MY INSURANCE COMPANY FOR ANY EXPENSES INCURRED FOR ORTHODONTIC TREATMENT AND FOR PAYMENT TO BE MADE DIRECTLY TO *SPARKS FAMILY ORTHODONTICS.* I ALSO GIVE AUTHORIZATION FOR THE OFFICE OF *SPARKS FAMILY ORTHODONTICS* TO RELEASE ANY NECESSARY INFORMATION TO MY INSURANCE COMPANY FOR THE PROCESSING OF ANY ORTHODONTIC CLAIM.

PATIENT NAME: ____________________

Primary Insurance: ____________________ Group #: ____________

Insurance Carrier Address: ____________________

Employer of Insured: ____________________

Name of Policy Holder: ____________________

Policy Holder Address: ____________________

Birthday of Policy Holder: ____________________

ID#: ____________________ SS#: ____________________

SS# required for insurance billing

Secondary Insurance: ____________________ Group #: ____________

Insurance Carrier Address: ____________________

Employer of Insured: ____________________

Name of Policy Holder: ____________________

Policy Holder Address: ____________________

Birthday of Policy Holder: ____________________

ID#: ____________________ SS#: ____________________

SS# required for insurance billing

SIGNATURE: ____________________ DATE: ____________

(authorization to bill your insurance)

PLEASE PROVIDE COPY OF INSURANCE CARD(S) OR NAME, ADDRESS, AND TELEPHONE NUMBER OF INSURANCE. THANK YOU.