

SHAMMAA ORTHODONTICS, INC.

Responsible Party Information

Name: _____ Relationship to Patient: _____

Address: _____
Mailing Address City State Zip

Home Phone: _____ Work Phone: _____ Date of Birth: _____

Marital Status: _____ Social Security: _____

Employer: _____ Occupation: _____

Employer Address: _____
Mailing Address City State Zip

Spouse's Name: _____ Spouse's Social Security: _____

Spouse's Employer: _____ Work Phone: _____



Insurance Information

Primary Orthodontic Insurance: Yes No

Insured's Name: _____ Insured Social Security: _____

Insured Date of Birth: _____

Insurance Company: _____ Group No. _____ Phone No. _____

Insured's Employer: _____

Secondary Orthodontic Insurance: Yes No

Insured's Name: _____ Insured Social Security: _____

Insured Date of Birth: _____

Insurance Company: _____ Group No. _____ Phone No. _____

Insured's Employer: _____

Medical:

Company Name: _____ Insured's Name: _____ Insurance Phone No. _____

Assignment of Insurance and Release

Please remember that insurance is considered a method of reimbursing the patient for fees paid directly to the provider and is not a substitute for payment. Some companies will pay fixed allowances for certain procedures and others pay a percentage of the charge. It is the patient's responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance company.

To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's records and Shammaa Orthodontics to file on the patient's behalf. A photocopy of this assignment is considered to be as valid as the original. I understand that I am financially responsible for all charges whether or not paid by the insurance carrier. I hereby authorize said assignee to release all information necessary to secure payment. Should the account be referred to an attorney for collection, the undersigned shall pay attorney's fees and collection expenses.

Patient or Guardian's Signature: _____ Date: _____