Account and Insurance Information

Paulus
ORTHODONTICS

MICHAEL PAULUS, DDS, MSD
WILLIAM PAULUS, DDS, MS

Patient's Name: _____
Date: _____

Responsible Party

Name _____
Relationship _____ SS # _____
Billing Address _____
_____
Home # (___) _____ Email _____
Employer _____
Work # (___) _____ Ext. _____

If you have dental insurance with orthodontic coverage,
please complete the following information.

Primary Dental Insurance

Policy owner's name _____
Relationship _____
Address _____
_____
City State Zip
Home # (___) _____ Birth Date _____
SS # _____
Employer _____
Work # (___) _____ Ext. _____
Employer's Address _____
_____
City State Zip
Insurance company name _____
Insurance company address _____
_____
City State Zip
Group # _____
Phone # _____
Maximum lifetime benefit _____
Percentage of benefit _____

Secondary Dental Insurance

Policy owner's name _____
Relationship _____
Address _____
_____
City State Zip
Home # (___) _____ Birth Date _____
SS # _____
Employer _____
Work # (___) _____ Ext. _____
Employer's Address _____
_____
City State Zip
Insurance company name _____
Insurance company address _____
_____
City State Zip
Group # _____
Phone # _____
Maximum lifetime benefit _____
Percentage of benefit _____
Is there a non-duplication of benefits clause? _____

I HAVE REVIEWED THE FOLLOWING PLAN. I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL COSTS OF TREATMENT.

_____
SIGNED (PATIENT OR PARENT IF MINOR) DATE

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE BELOW-NAMED DOCTOR OF THE GROUP INSURANCE BENEFITS OTHERWISE PAYABLE TO ME.

_____
SIGNED (INSURED PERSON) DATE