Panther Creek Orthodontics

4850 West Panther Creek #108
The Woodlands, TX 77381
281.367.7775 / 281.367.1247 FAX

FOR OFFICE USE ONLY

EFF. DATE:	
AGE LIMITS:	
DEDUCTABLE:	
PAID @:	
AUTO:	
MONTHLY:	QTRLY:
BENEFITS:	
ANY USED:	
WIP:	
NOTES: Payor ID #	

Please fill out this form in its entirety, we can not verify or accept dental insurance with any missing information

Name of Patient: _____ **Date of birth:** _____

DENTAL INSURANCE:

Name of Insured: _____ **Date of birth:** _____ **SSN:** _____
Employer Name: _____
Employer's Address: _____
Insurance Company: _____ **Phone number:** _____
Insurance Company Address: _____ **City:** _____**State:** _____ **Zip:** _____
Group number: _____ **ID#:** _____

IF YOU HAVE SECONDARY DENTAL INSURANCE COVERAGE, PLEASE COMPLETE:

Name of Insured: _____ **Date of birth:** _____ **SSN:** _____
Employer Name: _____
Employer's Address: _____
Insurance Company: _____ **Phone number:** _____
Insurance Company Address: _____ **City:** _____**State:** _____ **Zip:** _____
Group number: _____ **ID#:** _____

Please read and initial all highlighted areas below and return with your New Patient Form.

We are happy to file your first insurance claim for you at no additional charge.
If your dental insurance changes or terms during the course of treatment it is your responsibility to let our office know, otherwise the subscriber will be responsible for the balance if they have not paid within 90 days of the start date. _____
I have reviewed this claim and I authorize the release of any information related to this claim. _____

Signature of Patient (or Parent if patient is under 18): _____**Date:** _____

I hereby authorize all payments

Signature of Insured: _____ ___**Date:** _____