Remington Orthodontics

409 Broad Street Suite 101B
Sewickley, PA 15143
(412) 741-7700

974 Beaver Grade Rd. Suite B
Moon Township, PA 15108
(412) 741-7700

Date: _____ / _____ / _____

Patient Name: _____ Date of Birth:_____/_____/_____

Insured's (Employee) Name: _____

Insured's (Employee) Date of Birth:_____/_____/_____

Insurance Company _____

Insurance Co. Address _____

_____

Insurance Company Phone Number: (_____) _____

Insured's (Employee) Social Security Number: _____ – _____ – _____

or

Insured's (Employee) ID Number: _____

Employer: _____

Group Number: _____

Effective Date: _____

If more than one insurance, is this one primary or secondary? Primary Secondary

I authorize payment directly to Remington Orthodontics

_____

Signature of Insured

For office use only:

Date	_____	Submit Quarterly	_____
Spoke with	_____	Auto Monthly	_____
Lifetime maximum	_____	Auto Quarterly	_____
%	_____	Auto Annually	_____
Amount used	_____	Submit their form	_____
Age limit	_____		
Eligible	_____		
Pre-determination	_____		
Non-dup. clause	_____		
Deductible	_____		

Insurance Form