novus Orthodontics
The Next Generation In Orthodontics

PATIENT INFORMATION

Last Name	First Name	Nickname	SS NO.	Sex	Birthdate	Age

Mailing Address	City	State	Zip	School (if student)

#	Home Phone	Business Phone	Cell Phone # and Provider (for text reminders)	Fax

Email (for email reminders)	Name of Dentist	Date of last visit

Related patients that are or have been under our care	Names and Ages of other children

PARENT/ BILLING PARTY INFORMATION (please complete if patient is a minor)

PRIMARY NAME

_____

ADDRESS_____

CITY_____ST_____ZIP_____

CELL #_____WORK # _____

DOB_____/_____/_____

SS#._____-_____-_____

EMAIL_____

EMPLOYER_____

ADDRESS_____

CITY_____ST_____ZIP_____

INSURANCE CO: _____

GROUP #_____

POLICY ID:_____

INSURANCE CLAIMS ADDRESS:

_____

INSURANCE TELEPHONE# _____

SECONDARY NAME

_____

ADDRESS_____

CITY_____ST_____ZIP_____

CELL #_____ WORK #_____

DOB_____/_____/_____

SS#._____-_____-_____

EMAIL_____

EMPLOYER_____

ADDRESS_____

CITY_____ST_____ZIP_____

INSURANCE CO: _____

GROUP #_____

POLICY ID:_____

INSURANCE CLAIMS ADDRESS:

_____

INSURANCE TELEPHONE #:_____

PLEASE NOTIFY OUR OFFICE OF ANY CHANGES IN YOUR INSURANCE CARRIER AS SOON AS POSSIBLE.

INSURANCE PAYMENTS

The majority of insurance policies pay only a percent of the orthodontic fee based on your employer's contract with them. Ultimately, what your insurance carrier pays is between you, the carrier and the contract between your employer and the insurance carrier.

Upon presentation of your insurance card, we attempt to obtain a verbal description of coverage prior to claim submission. Verbal confirmation however does not guarantee payment. Benefit determination can be made only when a claim is submitted payable subject to your plan provisions and the coordination of benefits with other group plans when applicable.

AUTHORIZATION STATEMENT

I authorize the release of information necessary to process any claim for services provided by this establishment, and payment of benefits directly to this office. A copy of this authorization may be used in place of the original. I understand that I am responsible for any balances not covered by insurance.

Patients/Parents or members are responsible for notifying this office of any changes in orthodontic coverage, policy status, or change of carrier/administrator.

Name of Policyholder: _____

Signature: _____

Date: _____

WE ARE UNABLE TO ACCEPT DIVORCE DECREES AS ASSIGNENTS OF RESPONSIBILITY FOR A CHILD'S ORTHODONTIC BILLS. THE PARENT ACCOMPANYING THE CHILD SHOULD PAY FOR THE SEVICES AND SEED ANY REIMBURSEMENT FOR THE OTHER PARENT. TO THE BEST OF MY KNOWLEDGE, THE ABOVE INFORMATION IS COMPLETE AND CORRECT. I GIVE MY PERMISSION FOR ANY PHOTOGRAPHS, X-RAYS, OR STUDY MODELS TO BE USED FOR THE DISPLAYS AT SCIENTIFIC MEETINGS, PRESENTATION, AND PUBLICATION OF A SCIENTIFIC NATURE OR FOR STUDY GROUP PURPOSES TO FURTHER THE ART AND SCIENCE OF ORTHODONTICS. I, THE UNDERSIGNED, AGREE TO PAY FOR ATTORNEY FEES AND THEIR COSTS OF COLLECTIONS IN THE EVENT IT BECOMES NECESSARY TO USE ATTORNEY SERVICES TO SECURE PAYMENT OF THIS ACCOUNT.

Signature: _____

Date: _____