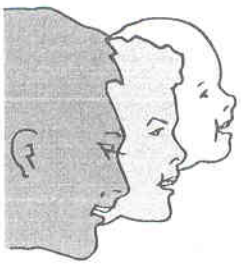

ADULT,
ADOLESCENT &
CHILD *ORTHODONTICS*

JOHN LISAC, D.D.S.

KENT HILL, D.M.D., M.S.
DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

INSURANCE INFORMATION

***PATIENT NAME**: _____

BIRTHDATE: _____/_____/_____

***EMPLOYEE/SUBSCRIBER NAME**: _____

ADDRESS: _____

CITY/STATE/ZIP: _____

PHONE #: (_____) _____-_____

BIRTHDATE: _____/_____/_____

SOCIAL SECURITY #: _____

***EMPLOYER NAME**: _____

***INSURANCE NAME**: _____

***DENTAL CLAIMS FILING ADDRESS**: _____

CITY/STATE/ZIP: _____

***INSURANCE PHONE #**: (_____) _____-_____

***INSURED IDENTIFICATION #**: _____

***GROUP AND/OR PLAN #**: _____

FILING INSTRUCTIONS & RELEASE

1. Information for insurance is required by the placement date to insure timely filing.
2. In the event that additional correspondence is needed there will be a charge of $20 for each piece requested beyond the normal insurance claim forms.
3. It is up to the insured to make sure the insurance is being resubmitted either monthly or quarterly based on the companies provisions.

I hereby authorize A.A.C. Orthodontics, P.C. to release any information regarding services rendered by them. By signing below I am authorizing the use of my signature on all claim forms that are submitted and understand that I am financially responsible for the fees for services rendered regardless, of insurance benefits.

_____ _____

Insured's Signature Date

Member American Association of Orthodontists

Please address all correspondence to: FAX (219) 836-8855
8231 Calumet Ave. • Munster, IN 46321 • (219) 836-0888 312 E. U.S. 30 • Schererville, IN 46375 • (219) 322-8008
2262 Morthland Drive (U.S. 30) • Valparaiso, IN 46383-5372 • (219) 531-0544