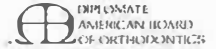


**ADULT,  
ADOLESCENT &  
CHILD ORTHODONTICS**

JOHN LISAC, D.D.S.

Member American Association of Orthodontists



**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



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Association of  
Orthodontists

\_\_\_\_\_  
Date