Madison Orthodontic Centers
Dr. Thomas P. Kuhn
6105 Monona Dr
Monona, WI 53716
608-663-8819 Fax 608-661-8257

TO OUR PATIENTS WITH ORTHODONTIC INSURANCE:

Our office is happy to cooperate with patients who are covered by orthodontic insurance. Dental insurance policies do not necessarily include benefits for orthodontic treatment. Please read your policy carefully to be fully aware of its benefits as well as its limitations. Should you still have questions about your coverage, please contact the Employee Benefits Office at your place of employment. Our business office will file your claims. We ask that you complete this insurance form and bring it to your consultation appointment. This information will be placed in our computer and any charges will be sent to your insurance company. **If you do not complete this form we cannot file your insurance. It will be your responsibility to pay any balance not covered by your orthodontic insurance benefits.**

Patient's Name:_____

Birthdate:_____ Gender (Please circle) Male Female

Relationship to Employee: Self___ Spouse____ Child___ Stepchild____ Other_

PRIMARY INSURANCE

Name of Employee:_____

Street Address:_____

City:_____ State:_____ Zipcode:_____

Birthdate:_____ Member ID# / Social Security#_____

Name of Insurance Company:_____

Street Address:_____

City:_____ State:_____ Zipcode:_____

Insurance Company phone #:_____ Group #:_____

Name of Employer:_____

Street Address:_____

City:_____ State:_____ Zipcode:_____

I hereby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me.
Signed (Insured Person)_____Date:_____

If there is more than one insurance benefit, please complete the back of this form.

SECONDARY INSURANCE

Patients relationship to Employee: Self___ Spouse____Child____Stepchild___ other ____

Name of Employee:_____

Street Address:_____

City:_____ State:_____ Zipcode:_____

Birthdate:_____ Member ID# /Social Security #_____

Name of Insurance Company:_____

Street Address:_____

City:_____ State:_____ Zipcode:_____

Insurance Company phone #:_____ Group #:_____

Name of Employer:_____

Street Address:_____

City:_____ State:_____ Zipcode:_____

I hereby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me.
Signed (Insured Person)_____Date:_____

If there is additional insurance coverage, please list detailed information below.