JAMES V. KARHOHS, D.D.S., M.S., P.C.
976 THREE MILE RD., N.W.
GRAND RAPIDS, MI 49544
(616) 784-4300 FAX: (616) 785-6060
drjkarhohs@choiceonemail.com

ORTHODONTIC INSURANCE INFORMATION

Please fill out the following information so that we may assist you in determining your orthodontic insurance benefit. If you have orthodontic coverage, it will be with your dental insurance carrier not your medical insurance carrier.

PATIENT'S NAME:_____ DATE OF BIRTH:_____

"PRIMARY DENTAL" INSURANCE INFORMATION

NAME OF INSURED:_____DATE OF BIRTH:_____

ADDRESS_____CITY_____

STATE_____ZIP_____ HOME PHONE_____

EMPLOYER_____

INSURANCE COMPANY_____

CONTRACT#_____GROUP#_____

INSURANCE ADDRESS_____CITY_____

STATE_____ZIP_____PHONE#_____

SECONDARY INSURANCE INFORMATION

NAME OF INSURED:_____DATE OF BIRTH:_____

ADDRESS_____CITY_____

STATE_____ZIP_____ HOME PHONE_____

EMPLOYER_____

INSURANCE COMPANY_____

CONTRACT#_____GROUP#_____

INSURANCE ADDRESS_____CITY_____

STATE_____ZIP_____PHONE#_____

I HEREBY AUTHORIZE RELEASE OF ANY INFORMATION RELATING TREATMENT TO THE INSURANCE LISTED ON THIS FORM.

_____
SIGNATURE DATE

I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO JAMES V KARHOHS DDS MS PC.

_____
SIGNATURE DATE