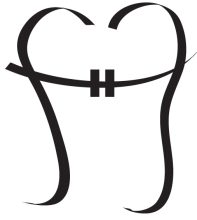


BIRMINGHAM



ORTHODONTICS

Insurance Information

Do you have orthodontic coverage? Yes No

Name of Primary Insurance Company: _____

Insurance Address: _____
Street City State Zip Code

Insurance Phone Number: _____ Group/Policy #: _____ ID #: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____ Policy Holder's SSN: _____

Policy Holder's Address: _____

Policy Holder's Employer: _____
Street City State Zip Code

Name of Secondary Insurance Company: _____

Insurance Address: _____
Street City State Zip Code

Insurance Phone Number: _____ Group/Policy #: _____ ID #: _____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____ Policy Holder's SSN: _____

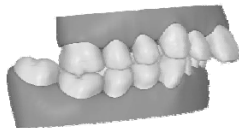
Policy Holder's Address: _____

Policy Holder's Employer: _____
Street City State Zip Code

1. What is your main concern?

Name: _____
 Date: _____

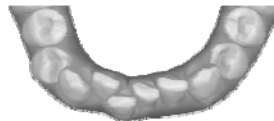
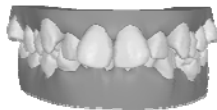
Overjet (Buck teeth)



Spaced teeth



Crooked/Crowded teeth



Other (please fill in) _____

2. What style of treatment would you prefer?



Metal Braces



Clear Braces



Invisalign Removable Clear Aligners

3. Do you have Orthodontic Insurance? Yes _____ No _____

4. Do you have a Group/Work/Insurance Discount Plan? Yes _____ No _____

5. If yes, please list Group/Work/Insurance and Discount: _____