DIPLOMATE AMERICAN BOARD OF ORTHODONTICS

110 N.E. Deadmore St.
Abingdon, VA 24212
(276) 628-1327

Westfall ORTHODONTICS

6719 Governor G. C. Peery Hwy
Suite 3500 Richlands, VA 24641
(276) 963-0332

CHAD WESTFALL, D.D.S.

INSURANCE INFORMATION:

- Patient Name: _____ Date: _____
- Patient Birth Date: _____
- Policy Holder Name: _____
- Policy Holder Birth Date: _____
- Policy Holder's SS# or ID#: _____
- Group # or any other #'s on card: _____
- Relationship to Patient: _____
- Place of Employment: _____
- Phone # of Insurance Company: _____
- Name and Address of Insurance Company: _____
- _____
- *I hereby authorize release of any information relating to the claim.
- *I hereby authorize payment of insurance benefits directly to the orthodontist.
- *I understand that I am personally responsible for any balance not paid by insurance.
- Signature: _____ Date: _____

Office Use Only

Date: _____ Orthodontic Coverage _____

Effective Date: _____ Waiting Period: _____

Age Limit: _____ Life Time Maximum: _____

Usual and customary Fee: _____ Will pay at what %: _____

Has any been used: _____ Any deductible? _____

How will this be paid – monthly or quarterly – and is it auto or do we bill each month or quarterly: _____

We are not a participating provider – will payments be paid to us or policy holder: _____