Hull & Coleman
ORTHODONTICS

James C. Hull, DDS, MS Grant G. Coleman, DMD, MS J. Turner Hull, DDS, MS

Orthodontic Insurance Information

To help us assist you in determining your orthodontic insurance benefit, please provide the following information:

Name of Patient: _____ _____ _____ Date Of Birth: _____/_____/_____
FIRST M LAST

Name of Insured: _____ _____ _____ Date Of Birth: _____/_____/_____
FIRST M LAST

Address: _____ _____
STREET APT #

_____ _____ _____
CITY ST ZIP CODE

Social Security Number of Insured: _____ - _____ - _____

Employer:
_____

Address:
_____
STREET

_____ _____ _____
CITY ST ZIP CODE

Insurance Company:
_____

Policy#:_____Group#:_____

Member Id # (IF DIFFERENT FROM SOCIAL SECURITY NUMBER):_____

Address of Insurance Company: _____
STREET

_____ _____ _____
CITY ST ZIP CODE

Insurance Company Telephone: _____

*Estimated Insurance Payment is the expected payment from your insurance plan. If the insurance payment is greater than expected, a credit will be issued to your account. You are responsible for the "Total Treatment Fee". If the insurance payment is less than expected, you will be required to pay the difference.

I HEREBY AUTHORIZE THE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM

SIGNATURE: _____DATE: _____/_____/_____

I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO THE ORTHODONTIST NAMED ABOVE

SIGNATURE: _____DATE: _____/_____/_____

PLEASE NOTIFY OUR OFFICE OF ANY CHANGES IN YOUR INSURANCE POLICY AS SOON AS POSSIBLE. THANK YOU.

7800 Providence Road, Suite 201
Charlotte, NC 28226
(704) 334-7203

www.HullandColeman.com

5941 Weddington-Monroe Road Road, Suite 103
Wesley Chapel, NC 28104
(704) 684-8080