HILLER ORTHODONTICS

Building Smiles. Treating People.

INSURANCE INFORMATION FORM

Patient Name _____ Date of Birth _____/_____/_____

Orthodontic Insurance Coverage? ☐ Yes ☐ No

If yes, please complete information below:

PRIMARY INSURANCE:

Name of Insurance Company _____

Address of Insurance Company _____

Phone Number of Insurance Company _____

Subscriber's Name _____

Subscriber's Address _____

Subscriber's Date of Birth _____/_____/_____ Gender _____

Subscriber's Relationship to Patient _____

Subscriber's Employer Name _____

Subscriber's Employer Address _____

Subscriber's ID Number _____

Note: Subscriber ID for NH Medicaid is 11 digits, for VT Medicaid is 7 digits, all other insurance is typically subscriber's social security number (9 digits)

Additional Orthodontic Insurance Coverage? ☐ Yes ☐ No

If yes, please complete information below:

Name of Insurance Company _____

Address of Insurance Company _____

Phone Number of Insurance Company _____

Dennis C. Hiller, DDS, MSD

1-888-HILLER-2 • smiles@hillerortho.com

HILLERORTHO.COM

HILLER ORTHODONTICS

Building Smiles. Treating People.

INSURANCE INFORMATION FORM

Subscriber's Name _____

Subscriber's Address _____

Subscriber's Date of Birth _____/_____/_____ Gender _____

Subscriber's Relationship to Patient _____

Subscriber's Employer Name _____

Subscriber's Employer Address _____

Subscriber's ID Number _____

Note: Subscriber ID for NH Medicaid is 11 digits, for VT Medicaid is 7 digits, all other insurance is typically subscriber's social security number (9 digits)

Dennis C. Hiller, DDS, MSD

1-888-HILLER-2 • smiles@hillerortho.com

HILLERORTHO.COM