Salmon Orthodontics
Dr. Marlin Salmon and Dr. deSa

Insurance Information Form

Patient Name _____ Date of Birth _____

Account # _____ First Visit Date _____

Records Date _____

Today's Date _____

Insured Name _____ Relationship_____

Social Security # _____ Date of Birth _____

Insurance Company Name _____

Address for Claims _____

_____

Policy # Prefix if any and No. _____

Employer – Insured _____

Second Coverage – if any

Insured Name _____ Relationship_____

Social Security # _____ Date of Birth _____

Insurance Company Name _____

Address for Claims _____

_____

Policy # Prefix if any and No. _____

Employer – Insured _____