NEIL M. WALLE, DDS, MS
Specialist in Orthodontics
DENTAL INSURANCE INFORMATION

Patient Name: _____ DOB: ____/____/____

Primary Coverage

Policyholder Name: _____ Employer _____
Policy/ID#: _____Group No. _____ DOB: ____/___/____
Relationship to Patient: _____
Name of Dental Insurance: _____
Insurance Claims Address: _____
Street/P.O. Box City
_____ Phone: _____
State/Zip

Secondary Coverage

Policyholder Name: _____ Employer _____
Policy/ID#: _____Group No. _____ DOB: ____/___/____
Relationship to Patient: _____
Name of Dental Insurance: _____
Insurance Claims Address_____
Street/P.O. Box City
_____ Phone: _____
State/Zip

Authorization to Release Information and Payment to Provider:

Patient/Guardian Signature_____ Date ____/____/____

We gladly bill your insurance company for any services rendered, however, the final responsibility for payment rests with the patient/guardian. Please notify us immediately with any changes in coverage.