

# BracePlaceUSA

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## Orthodontic Insurance Information

Please present your orthodontic insurance card (s) at the first appointment

Patient Name \_\_\_\_\_

### **Primary Orthodontic Insurance:**

Subscribers Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_

Address (if different from patient): \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home phone number \_\_\_\_\_ Cell Phone \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ Business Phone # \_\_\_\_\_

Business Address \_\_\_\_\_

Orthodontic Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

SSN# \_\_\_\_\_ Subscribers# \_\_\_\_\_

Group# \_\_\_\_\_ Policy# \_\_\_\_\_

### **Secondary Orthodontic Insurance: (If patient is covered by an additional plan)**

Subscribers Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_ Birthdate \_\_\_\_\_

Address (if different from patient): \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Home phone number \_\_\_\_\_ Cell Phone \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ Business Phone # \_\_\_\_\_

Business Address \_\_\_\_\_

Orthodontic Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_

SSN# \_\_\_\_\_ Subscribers# \_\_\_\_\_

Group# \_\_\_\_\_ Policy# \_\_\_\_\_