BEL AIR ORTHODONTICS

STEPHEN L. GODWIN, DMD, DMSc, LLC

SPECIALIST IN ORTHODONTICS FOR ADULTS AND CHILDREN

CHANGE OF DENTAL INSURANCE FORM

This form must be completed in full to process your insurance benefit*

Today's Date:_____

Patient's Name:_____ **Birthdate:**_____

Patient's Address:_____ **Phone:**_____

Old Insurance Co. Name:_____
Policy Termination Date:_____

New Insurance Co. Name:_____
Effective Date of Policy:_____

Ins. Address:_____

Phone:_____ **Group #:**_____ **Policy #:**_____

Policy Owner's Name:_____ **SS#:**_____

Relationship to Patient:_____ **Policy Holder's DOB:**_____/_____/_____

Policy Owner's Address:_____ **Phone:**_____

Employer:_____ **Employer's Address:**_____

I certify that the information I have provided is true and correct to the best of my knowledge. I authorize Bel Air Orthodontics to apply for health insurance benefits on my behalf. I understand by providing the above information does not guarantee payment from the new insurance carrier.

_____

Signature of Legal Guardian or Policy Holder **Date**

Member American Association of Orthodontists

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