BUENA VISTA ORTHODONTICS
MERILYNN YAMADA, D.D.S. & ASSOCIATES

PATIENT INSURANCE INFORMATION

Date form completed	

Patient Name		DOB	

Subscriber Name		DOB	
Subscriber Relation to Patient			
Subscriber's SS#		ID #	
Subscriber's Employer			

Insurance Co. Name		Group #	
Ins Co Address		Effective date	
State and Zip Code			
Ins Co telephone #			

Is this Ins Primary?		
Any Dual Coverage?		If yes, please complete 2nd form

Please fill out the above information completely so that we may bill your insurance company as soon as possible.

Please note that having orthodontic coverage or billing your insurance is not a guarantee of payment from the orthodontic benefits throughout treatment and you are responsible for the full usual and customary orthodontic fee including any portion that is not paid by your insurance company.

If you have a secondary insurance: Before a secondary insurance can be billed, you are responsible for providing our office with the Explanation of Benefits (EOB) from the primary insurance. Please contact this office if you have not received your EOB within 3-4 weeks.

I have read and understood the above insurance information. I understand that if I want my insurance billed by this office, I am responsible for getting necessary forms and information to this office in a timely manner and that failure to do so may delay or jeopardize obtaining insurance benefits.

Signed_____ Date_____

BVO Staff_____ Date_____

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