



ORTHODONTICS FOR ADULTS AND CHILDREN

SCOTT D. GALKIN, D.M.D.

ORTHODONTIC LICENSE #5286

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INSURANCE INFORMATION

Patient Name: _____

Address: _____

City: _____ St: _____ Zip: _____ Phone: _____

Sex: _____ Martial Status: _____ D.O.B.: ____/____/____

Patient's Social Security #: _____

Who is Financially Responsible for the Bill: _____

Employer

Address
City, State, Zip

Work Phone: _____

Employee Type: (please x)

Retired _____
Employed Full Time _____
Employed Part Time _____
Not Employed _____

Student Type: (please x)

Student Full Time _____
Student Part Time _____
Non-Student _____

Insurance #1

Address
City, State, Zip

Insured: _____

Sex: _____ Martial Status : _____

Relationship: _____

Date of Birth: ____/____/____

Policy Number: _____

Policy Through: _____

Group Number: _____

Employer: _____

City, St, Zip: _____

Subscriber's SS# _____

Insurance #2

Address
City, State, Zip

Insured: _____

Sex: _____ Martial Status : _____

Relationship: _____

Date of Birth: ____/____/____

Policy Number: _____

Policy Through: _____

Group Number: _____

Employer: _____

City, St, Zip: _____

Subscriber's SS# _____

Release and Assignment

I authorize release of my information necessary to process my insurance claim and assign and require payment currently to my doctor.

X _____