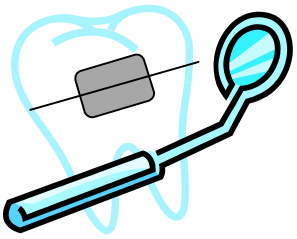

PHILIP M. NISCO, D.D.S., Inc
Orthodontist
Diplomate, American Board of Orthodontics

INSURANCE INFORMATION

Patient's Name: _____Sex: F / M

Patient's Birthday: _____

Employee Name: _____

Employee's Date of Birth: _____

Employer's Company Name: _____

Insurance Company Name: _____

Insurance Company Phone #: _____

SS #_____ Group # _____

ID#_____

TERMS OF VERIFICATION

Any insurance information provided to you by this office is only estimated and can change at any time. For your convenience we will verify benefits over the phone or via fax before treatment has begun. However, we cannot be held responsible for misquotes or terminations of benefits before, during or after orthodontic treatment.

If you have any questions concerning your benefits as they relate to orthodontic treatment, we suggest that you contact your insurance provider or human resource department directly.

If insurance terminates we will prorate your account and issue a new monthly payment. We are happy to bill your insurance as a courtesy in order for you to receive the maximum benefit allowed. However, as our office is not an agent of your insurance carrier, we cannot guarantee payments. Thus, regardless of insurance benefits, you are responsible for the account.

Please mail this information as soon as possible to verify eligibility before your visit.

Sincerely,

Michelle Wright
Financial and Treatment Coordinator

Specialist in Orthodontics & Dentofacial Orthopedics
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