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Tualatin, OR 97062

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### Account and Insurance Information

Patient's Name \_\_\_\_\_  
Date \_\_\_\_\_

Responsible Party	
Name	_____
Relation	_____ SS _____
Billing Address	_____
Home #	_____ e-mail _____
Employer	_____
Work #	_____ Ext _____

If you have dental insurance with orthodontic coverage, please complete the following information.

Primary Dental Insurance	
Policy Owner's Name	_____
Relation	_____
Address	_____
City	State Zip
Home #	Birthdate _____
SS#	_____
Employer	_____
Work #	Ext _____
Employer's Address	_____
Insurance Company Name	_____
Insurance Company Address	_____
City	State Zip
Group #	_____
Phone #	_____

Secondary Dental Insurance	
Policy Owner's Name	_____
Relation	_____
Address	_____
City	State Zip
Home #	Birthdate _____
SS#	_____
Employer	_____
Work #	Ext _____
Employer's Address	_____
Insurance Company Name	_____
Insurance Company Address	_____
City	State Zip
Group #	_____
Phone #	_____

### Office Use Only

Primary
Insured: _____
Insurance Co. Code: _____
Relationship: _____
Notes: _____
_____
_____

Secondary
Insured: _____
Insurance Co. Code: _____
Relationship: _____
Notes: _____
_____
_____