MICHAEL R. SABAT DDS., MS., INC.

6789 RIDGE RD 8865 BRECKSVILLE RD
440-845-3360 440-526-0175

If you have dental insurance benefits we would like to help you maximize any orthodontic benefits that may be available for you and your children. **Please complete the information on the front of this page and <u>return it to us in the enclosed envelope BEFORE your scheduled appointment</u>** so we can call your insurance carrier and have your information ready at your next appointment.

If each parent/guardian has insurance coverage, please make sure to give us all the information needed to access the information needed to coordinate and estimate your benefit.

Patient Name: _____ Birth date: _____ Phase: _____

PRIMARY INSURANCE CARRIER INFORMATION

Insured Name: _____ Birth date: _____

Subscriber ID #:_____ or SS #: _____Group #: _____

Employer Name: _____

Dental Insurance Company: _____ Phone #: _____

Dental Insurance Co. Address: _____

Relationship to Patient: circle one FATHER MOTHER SPOUSE GUARDIAN STEPDAD STEPMOM

OTHER _____

SECONDARY INSURANCE CARRIER INFORMATION

Insured Name: _____ Birth date: _____

Subscriber ID #: _____ or Social Security #: _____Group #: _____

Employer Name: _____

Dental Insurance Company: _____ Phone #: _____

Dental Insurance Co. Address: _____

Relationship to Patient: circle one FATHER MOTHER SPOUSE GUARDIAN STEPDAD STEPMOM

OTHER _____

PARENT/GUARDIAN SIGNATURE: _____ DATE: _____