Dr. Gary Thomas Puccio ***255 Schuurman Road***
Board Certified Specialist In Orthodontics ***Castleton On Hudson, NY 12033***

Phone: 518 477-2727 Fax: 518 477-2728

Please complete this form completely if the patient has **Orthodontic coverage**. If necessary, please contact your insurance company directly to confirm orthodontic coverage. Ask for the **lifetime orthodontic maximum benefit amount** and how exactly the benefit is paid to you, i.e. monthly, quarterly, yearly. This way we can coordinate submissions with Insurance payment schedules.

Name of Patient _____ Date: _____

Primary Dental Insurance Coverage

Insured's Name _____

Insured's Date of Birth _____ Insurance ID Number _____

Employer _____ Group Number_____

Insurance Company _____

Address_____

Phone Number _____

Insurance Effective Date: _____

Insured's Signature (to be kept on file) _____

Secondary Dental Insurance Coverage

Insured's Name _____

Insured's Date of Birth _____ Insurance ID Number _____

Employer _____ Group Number_____

Insurance Company _____

Address _____

Phone Number _____

Insurance Effective Date: _____

Insured's Signature (to be kept on file) _____