

Insurance Information



SOUTHERN
ORTHODONTIC
SPECIALISTS, P.C.

HUNTER B. HARRISON, D.D.S., M.S.

Office Use Only

TC w/ _____

Date _____

Maximum _____% _____

Remaining Benefit _____

Deductible _____

Effective Date _____

Waiting Period _____

Age Limit _____

Date _____

Patient's Name _____

Patient's Date of Birth _____

Employee's Information

Employee's Name _____ SSN: _____

Employee's Date of Birth _____ Group # _____

Employer _____ Employment Status Active Retired

Insurance Company _____ Ins. Co. Phone _____

Address for Claims Submission _____

Employee's Signature _____

I hereby authorize payment directly to
Southern Orthodontic Specialists, P.C.