

DeWayne B. McCamish, DDS, MS    Jeril R. Cooper IV, DMD    Kenneth C. Dyer IV, DDS, MDS

4610 Brainerd Road, Suite 3  
Chattanooga, TN 37411-3836  
423-624-6525  
fax: 423-629-9889

<b>Patient's Name:</b>	<b>Date of Birth:</b>
	<b>Patient's SS #:</b>
<b>Provide names of other members on file:</b>	

**About the Insured:**

<b>Insured's Name:</b>		<b>Date of Birth:</b>		
<b>Address:</b>				
<b>City:</b>		<b>State:</b>	<b>Zip Code:</b>	
<b>Patient's Relationship to insured:</b>	<b>Self:</b>	<b>Spouse:</b>	<b>Child:</b>	<b>Other:</b>
<b>Home Phone:</b>		<b>Work Phone:</b>		

**About the Company the Insured Works for:**

<b>Employer:</b>		
<b>Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>

**About the Insurance Policy:**

<b>Is the Insurance Coverage: Medical:</b>	<b>Effective Date:</b>	
<b>Dental:</b>		
<b>Name of the Insurance Company</b>		
<b>Address:</b>		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>
<b>Telephone Number:</b>		
<b>Group Number:</b>	<b>ID Number:</b>	

I authorize release of any information relating to this claim to my insurance company.

<b>Signature:</b>	<b>Date:</b>
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I authorize payment of any insurance benefits, otherwise payable to me, directly to Drs. McCamish, Cooper, & Dyer.

<b>Signature:</b>	<b>Date:</b>
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**Please complete one of these forms for EACH Insurance policy you think may cover orthodontic treatment. We must have ALL the information requested before we can file your insurance claim.**

**Please return completed form to the address shown above.**