Kulkarni Orthodontics
566 N. Main St. (Rt. 741), Springboro OH 45066
Tel: (937) 748-0505, (513) 770-6707 Fax: (937) 748-8235 Email: drrajbraces@earthlink.net

Follow-up Patient Information Form:

Full Name: _____

Home Phone: ( )_____ **Cell Phone:** _____

General Dentist: _____

E-Mail Address: _____

School: _____

Home Address: _____

City: _____ **State:** _____ **Zip:** _____

Has your dental insurance changed? If so, please give us the new information: _____

_____

I authorize my insurance company to pay to the orthodontist or orthodontic group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
I authorize the orthodontist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.
I also hereby verify that the above information is accurate.

Signature: _____ **Date:** _____

Relationship to patient: _____ **Email:** _____