



A. Valeria Poggio, DDS, MS

ORTHODONTIC INSURANCE  
INFORMATION

891 Kuhn Dr Ste 205  
Chula Vista, CA 91914  
Tel. (619) 482-2412  
Fax (619) 482-2442

DATE \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**In order to assist you in receiving the greatest benefit from your orthodontic insurance, it will be helpful to have the following information completed.**

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Relationship to insured \_\_\_\_\_

Insured Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security # \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Policy or Group # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Telephone (800 # if available) \_\_\_\_\_

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**If the patient is covered by a second insurance policy; please complete the following information for the second insurance policy.**

Insured Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security # \_\_\_\_\_

Patient relationship to the insured \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Policy or Group # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Telephone (800 # if available) \_\_\_\_\_

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**If the patient is covered by a third insurance policy, please complete the following information for the third insurance policy.**

Insured Name \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security # \_\_\_\_\_

Patient relationship to the insured \_\_\_\_\_

Employer \_\_\_\_\_

Address \_\_\_\_\_

Insurance Co. \_\_\_\_\_ Policy or Group # \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_

Insurance Co. Telephone (800 # if available) \_\_\_\_\_

I AUTHORIZE RELEASE OF ANY INFORMATION RELATING TO THIS CLAIM.

Signature (Patient or Parent of minor) \_\_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_