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 use this form to help you keep track of your orthodontic benefits. If necessary, please contact your insurance company directly to confirm your orthodontic coverage. Ask for the **lifetime orthodontic maximum benefit amount** and **exactly how the benefit is paid to you** (i.e.: monthly, quarterly and yearly). Submissions must match benefit schedule to avoid confusion and delay in payments of benefits. Because every benefit plan is different and changes from year to year, you will need to confirm exactly what your benefits are yearly and **report any changes to us.**

Name of Patient _____

Primary Insured Name_____

Dental Insurance Company, ID Number & Phone Number_____
_____

Maximum Lifetime Orthodontic Benefit_____
How it is paid (i.e.: monthly, qtrly, yearly)? _____
For how long (i.e.: 1 year, 20 mos., etc.)?_____
Exclamation of Benefits (EOB) received _____Date: _____
Date appliances were placed_____

Copy given to Dr. Puccio's office for processing secondary insurance, please check box of Yes or No

Insurance checks received:

Insurance Check Number: _____Amount:_____Date:_____ □ Yes □ No
Insurance Check Number: _____Amount:_____Date:_____ □ Yes □ No
Insurance Check Number: _____Amount:_____Date:_____ □ Yes □ No
Insurance Check Number: _____Amount:_____Date:_____ □ Yes □ No
Insurance Check Number: _____Amount:_____Date:_____ □ Yes □ No
Insurance Check Number: _____Amount:_____Date:_____ □ Yes □ No
Insurance Check Number: _____Amount:_____Date:_____ □ Yes □ No
Insurance Check Number: _____Amount:_____Date:_____ □ Yes □ No

Secondary Insured Name _____

Dental Insurance Company, ID Number & Phone Number _____
_____

Maximum Lifetime Orthodontic Benefit_____
How it is paid (i.e.: monthly, qtrly, yearly)? _____
For how long (i.e.: 1 year, 20 mos., etc.)?_____
Exclamation of Benefits (EOB) received _____Date: _____

Insurance checks received:

Insurance Check Number: _____Amount:_____Date:_____
Insurance Check Number: _____Amount:_____Date:_____
Insurance Check Number: _____Amount:_____Date:_____
Insurance Check Number: _____Amount:_____Date:_____
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