DAVID L. MCINTOSH, D.M.D.

Please supply us your insurance information prior to your appointment so we can confirm your orthodontic coverage. Please submit to us via email: infomcintosh@gmail.com, or fax 407-644-5090). As a courtesy, we are happy to submit charges to your insurance company. **This information is vital in order for us to accept payments, otherwise we will have the insurance company reimburse you with any benefits.**

Thank you very much for your assistance!

INSURANCE INQUIRY FORM

Date:_____

Patient's name: _____DOB: _____ Age: _____

Subscriber's name: _____ DOB: _____

SS# or Subscriber ID #: _____ ___Employer: _____

Insurance company: _____ Phone #: _____- _____

Group name: _____ Group #: _____

Claims mailing address: _____

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