Dental Insurance Information Form

This form is for DENTAL coverage only. The information you provide will be used to verify your dental benefits, so please fill out this form completely. As a courtsey, we are happy to file an isnraucne claim on your behalf once active treatment is initiated. Without this inforamtion we are unable to file your claim.

Patient Name:____ Patients DOB:________________________

Primary Insurance

Company Name: ____ Phone #:___________________

Insurance Co. Address:____

Subscriber's Full Name:____

Relationship to patient:___________________________________ DOB:______________________________

Subscriber's Address____

Social Security #:____________________ Subscriber ID #_________________Group #:_____________

Employer:____ Work Phone #:______________________

Secondary Insurance

Company Name: ____ Phone #:________________________

Insurance Co. Address:____

Subscriber's Full Name:____

Relationship to patient:___________________________________ DOB:______________________________

Subscriber's Address____

Social Security #:____________________ Subscriber ID #_________________Group #:_______________

Employer:____ Work Phone #:________________________