

Dental Insurance Information

Patient's Name _____

1. Primary Insurance

Insured's Name _____

Insured's SS# / ID# _____

Insured's Birthdate _____

Insured's Employer _____

Group# _____

Patient's Relationship to Insured _____

DENTAL Insurance Company Name _____

DENTAL Insurance Company Address _____

_____ Telephone _____

2. Secondary Insurance

Insured's Name _____

Insured's SS# / ID# _____

Insured's Birthdate _____

Insured's Employer _____

Group# _____

Patient's Relationship to Insured _____

DENTAL Insurance Company Name _____

DENTAL Insurance Company Address _____

_____ Telephone _____

Please sign here authorizing release of information to insurance company.

_____ Date _____

Please sign here authorizing payment of benefits to the doctor.

_____ Date _____

In order to file your insurance, we must have the above information on your first office visit.