

## Dental Insurance Information

Patient's Name \_\_\_\_\_

### 1. Primary Insurance

Patient's Birthdate \_\_\_\_\_

Insured's Name \_\_\_\_\_

Insured's SS# / ID# \_\_\_\_\_

Insured's Birthdate \_\_\_\_\_

Private Policy Yes \_\_\_\_\_ No \_\_\_\_\_

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 \_\_\_\_\_

Private Policy Yes \_\_\_\_\_ No \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Group# \_\_\_\_\_

Patient's Relationship to Insured \_\_\_\_\_

DENTAL Insurance Company Name \_\_\_\_\_

DENTAL Insurance Company Address \_\_\_\_\_

\_\_\_\_\_  
Telephone \_\_\_\_\_

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

We participate in the Delta Dental Network. However, we will gladly file your insurance regardless of your carrier. I hereby authorize and request payment directly to the doctor.

Signature \_\_\_\_\_