

DENTAL INSURANCE INFORMATION



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If you have dental insurance and would like us to file a claim please fill out this form and bring it with you to your appointment with us.

DENTAL INSURANCE COMPANY

Insurance Company Name: _____

Insurance Company Address: _____

City: _____ State: _____ Zip: _____

Insurance Company Phone #: _____

Insurance Policy #: _____ Insurance Group #: _____

Is this insurance carrier Primary / Secondary (please check one)

PRIMARY INSURED INFORMATION

Insured Name: _____

Insured Address: _____

City: _____ State: _____ Zip: _____

Insured phone #: _____

Insured Social Security #: _____ Birthdate: ____/____/____

Insured Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Employer phone #: _____

PATIENT INFORMATION

Patient Name: _____

Patient Address (if different from insured): _____

City: _____ State: _____ Zip: _____

Please remember to bring this completed form along with your insurance card with you to your appointment. THANK YOU!