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.

Signature _____