Dental Insurance Information

Patient's Name: _____
Last **First** **Middle Initial**

Primary Dental Plan

Dental Plan Name & Address: _____

_____

Telephone : _____

Name of Insured: _____
Last First Middle Initial

Is insured a patient here? o Yes o No

Insured's Birth Date: _____ ID # _____ Group # _____

Insured's Address: _____
Street City State Zip

Insured's Employer Name: _____

Employer Address: _____
Street City State Zip

Patient relationship to insured: o Self o Spouse o Child o Other _____

Secondary Dental Plan (If Any)

Dental Plan Name & Address: _____

_____

Telephone: _____

Name of Insured: _____
Last First Middle Initial

Is insured a patient here? o Yes o No

Insured's Birth Date: _____ ID # _____ Group # _____

Insured's Address: _____
Street City State Zip

Insured's Employer Name: _____

Employer Address: _____
Street City State Zip

Patient relationship to insured: o Self o Spouse o Child o Other _____

Please provide a copy of your dental plan I.D. card & an outline of the plan limitations.