



Please complete thoroughly and write legibly so that we may best assist you.

PRIMARY DENTAL INSURANCE INFORMATION

Name of Patient: _____ Date of Birth: _____
Name of Insured: _____ Date of Birth: _____
Street Name/Number of Insured: _____
City, State, ZIP of Insured: _____
Social Security # of Insured: _____ Telephone # of Insured: _____
Policy or Group # of Insured: _____ ID # of Insured: _____
Employer Name: _____
Name of Insurance Company: _____
Insurance Company Address: _____
Insurance Company Telephone #: _____

OFFICE USE ONLY

Checked By: _____ Date: _____ Contact Person: _____
Maximum Coverage: \$ _____ Lifetime or Yearly paid at _____ %
Deductible: \$ _____ Age Limit: _____ Other Limitations: _____
Amount Used to Date: _____ Pre-Auth Required? Y N
Do They Pay an Initial Banding Fee? Y N
Benefit is Paid: Monthly Quarterly Biannual Annual Other Benefit Pd? Prov Sub
Bill: Auto Manual Payor ID#: _____

SECONDARY DENTAL INSURANCE INFORMATION

Name of Patient: _____ Date of Birth: _____
Name of Insured: _____ Date of Birth: _____
Street Name/Number of Insured: _____
City, State, ZIP of Insured: _____
Social Security # of Insured: _____ Telephone # of Insured: _____
Policy or Group # of Insured: _____ ID # of Insured: _____
Employer Name: _____
Name of Insurance Company: _____
Insurance Company Address: _____
Insurance Company Telephone #: _____

OFFICE USE ONLY

Checked By: _____ Date: _____ Contact Person: _____
Maximum Coverage: \$ _____ Lifetime or Yearly paid at _____ %
Deductible: \$ _____ Age Limit: _____ Other Limitations: _____
Amount Used to Date: _____ Pre-Auth Required? Y N
Do They Pay an Initial Banding Fee? Y N
Benefit is Paid: Monthly Quarterly Biannual Annual Other Benefit Pd? Prov Sub
Bill: Auto Manual Payor ID#: _____