## **Insurance Information**

All insurance information must be completely filled out or insurance will not be submitted and you will be responsible for payment in full. If any information is incorrect or not completely filled out and your claim is denied, you will be responsible for submitting your own claim and full payment will be due. We need medical insurance cards regardless of whether or not we are in network with them or not. As we will be submitting claims on your behalf, please be on the lookout for anything your insurance company sends in the mail as some of these are time sensitive.

## **Primary Policy Holders Information**

Last: F	irst:	MI				
Birth Date://	SS#	Sex: _	Age:		_Street	
Address:	City:		State:	Zip: _		_ Home
phone: ( ) W	ork phone: ( )					
Employer name:						
Employer name:Street Address:	City: _		Stat	e:	Zip:	
#1 Primary Dental Insurance i	<u>nfo:</u>					
Insurance Company Name:						
Address to Submit Claims:	City:		State:		Z	ip:
Ins. Co. Phone #: ( )	City: Member ID #:		and/or Group#			
#1 Primary Medical Insurance	e info:					
Insurance Company Name:						
ddress to Submit Claims: City:		ty:	State:		Zi	o:
Ins. Co. Phone #: ( ) -	dress to Submit Claims: City: Co. Phone #: ( ) Member ID #:		and/or Group#			
LastF	irst	MI	_			
Birth Date//	SS#	Sex:_	Age:	S1	treet	
Address:			State:	Zip:		Home
Phone: ( )						
Employer name:						
Street Address:	Cıty: _	City:		State: Zıp:		
#2 Secondary Dental Insurance	ea info:					
Insurance Company Name:						
Address to Submit Claims:		ity:		State	. 7	Zin:
Ins Co Phone #: () -	Member ID #:		and/or Group#		· 2 )#	лр
				<b></b>	· · · · · · · · · · · · · · · · · · ·	<del></del> -
#2 Secondary Medical Insurar	nce info:					
Insurance Company Name:						
Address to Submit Claims:		_ City:	State: Zip:		ip:	
Ins. Co. Phone#: ( )	Member ID #:		and/or Group#			