## **INSURANCE INFORMATION**

\*ALL INSURANCE INFORMATION MUST BE COMPLETELY FILLED OUT IF YOU WISH US TO SUBMIT A CLAIM ON YOUR BEHALF. WHILE WE WILL MAKE EVERY ATTEMPT TO OBTAIN REIMBURSEMENT FOR YOU WE CANNOT GUARANTEE WHAT, IF ANYTHING YOUR CARRIER(S) WILL PAY, NOR THE AMOUNT OF TIME IT WILL TAKE FOR THEM TO PROCESS CLAIMS.

## PRIMARY Policy Holders Information

Last: First:	N	1I			
Birth Date:/ SS#	S	Sex:	Age: _		
Street Address: City:			State:	Zip:	
Street Address: City: Work phone: (	)				
Employer name:	Employer	address:			
Street					
StreetSt	ate:	Zip: _			
#1 Primary Dental Insurance info:					
Insurance Company Name:					
Insurance Company Name:  Address to Submit Claims:  Ins. Co. Phone #: ( ) - Member ID #	ity:		State	e:	Zip:
Ins. Co. Phone #: ( ) Member ID #	<b>#:</b>		and/or C	3roup#_	
#1 Primary Medical Insurance info:					
Insurance Company Name:					
Address to Submit Claims: Cit	ty:		State:		Zip:
nsurance Company Name:  Address to Submit Claims: City:		and/or Group#			
Last First Street Address: City: Home Phone: ( ) Work phone					
Birth Date/ SS#	;	Sex:	Age:		
Street Address: City:			_ State:	Zip:_	
Home Phone: ( ) Work phone	e: ( )				
Employer name:Employer address:					
StreetSt					
CitySt	ate:	Zip: _			
#2 Secondary Dental Insurance info:					
Insurance Company Name:					
Address to Submit Claims:C	City:		State	e:	Zip:
Ins. Co. Phone #: ( ) Member ID #: _	ess to Submit Claims: City: City: Co. Phone #: ( ) Member ID #:		and/or Group#		
#2 Secondary Medical Insurance info:					
Insurance Company Name:					
Address to Submit Claims:	City:		State	:	Zip:
Ins. Co. Phone#: ( ) - Member ID #:			and/or Group#		