



## DENTAL INSURANCE INFORMATION

| DOB:

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### Primary Insurance Information

Do you have a dental insurance?	<b>YES</b>
Would you like to upload insurance card photo?	<b>NO</b>
Patient's relationship to the Insurance Holder	
Insurance Holder's name	
Insured Date of Birth	
Insured Address	
Insured Address	
Insured City	
Insured State	
Insured ZIP	
Insured Employer's Name	
Dental Insurance Company	
ID Number	
Group Number	
Insurance Plan Name	
Insurance Company Contact	

### Secondary Insurance Information

Do you have a secondary dental insurance?	
Would you like to upload insurance card photo?	
Patient's relationship to the Insurance Holder	
Insurance Holder's name	
Insured Date of Birth	
Insured Address	
Insured Address	
Insured City	
Insured State	
Insured ZIP	
Insured Employer's Name	
Dental Insurance Company	
ID Number	
Group Number	
Insurance Plan Name	
Insurance Company Contact	