Dental Insurance Information Form

This form is for DENTAL coverage only. The information you provide will be used to verify your dental benefits, so please fill out this form completely. As a courtesy, we are happy to file an insurance claim on your behalf once active treatment is initiated. Without this information we are unable to file your claim.

Patient Name:_____ Patients DOB:_____

Primary Insurance

Company Name: _____ Phone #:_____

Insurance Co. Address:_____

Subscriber's Full Name:_____

Relationship to patient:_____ DOB:_____

Subscriber's Address_____

Social Security #:_____ Subscriber ID #_____Group #:_____

Employer:_____ Work Phone #:_____

Secondary Insurance

Company Name: _____ Phone #:_____

Insurance Co. Address:_____

Subscriber's Full Name:_____

Relationship to patient:_____ DOB:_____

Subscriber's Address_____

Social Security #:_____ Subscriber ID #_____Group #:_____

Employer:_____ Work Phone #:_____