Dental Insurance Information

Patient's Name _____

1. Primary Insurance

Patient's Birthdate _____

Insured's Name _____

Insured's SS# / ID# _____

Insured's Birthdate _____

Private Policy Yes _____ No _____

Insured's Employer _____

Group# _____

Patient's Relationship to Insured _____

DENTAL Insurance Company Name _____

DENTAL Insurance Company Address _____

_____

_____Telephone _____

2. Secondary Insurance

Insured's Name _____

Insured's SS# / ID# _____

Insured's Birthdate _____

Private Policy Yes _____ No _____

Insured's Employer _____

Group# _____

Patient's Relationship to Insured _____

DENTAL Insurance Company Name _____

DENTAL Insurance Company Address _____

_____

_____Telephone _____

In order to file your insurance, we must have the above information on your first office visit.

We participate in the Delta Dental Network. However, we will gladly file your insurance regardless of your carrier. I hereby authorize and request payment directly to the doctor.

Signature _____