INSURANCE INFORMATION

DATE _____

PLEASE NOTE: The information requested below is required by your insurance company to file a claim. We will be unable to file your insurance without all requested information. In addition, please allow us to copy your insurance card.

Patient Name _____ *Birthdate* _____

PRIMARY Dental Insurance Company _____

*Phone #*_____ *Group # or Certificate #*_____

Subscriber _____ *Employer* _____

Subscriber birth date _____ *ID # or Social Security #* _____

SECONDARY Dental Insurance Company _____

*Phone #*_____ *Group # or Certificate #*_____

Subscriber _____ *Employer* _____

Subscriber birth date _____ *ID # or Social Security #* _____