INSURANCE INFORMATION

All patients who have dental insurance must fill out the following information in order for us to file your dental claims. We also need a copy of your dental insurance card on file.

Name of Policy Holder ____
Social Security # _______________**Date of Birth** ____________ **Group #** _______
Policy Holders Employer ____
Address for Employer ____________________**City**_________**State**____**Zip**_____
Name of Insurance Company ____
Address for Insurance Company ____
City______________________**State**__________**Zip**_______**Phone**_____________

If patient is a full/part time student and on parents insurance please fill out the following…

Name of school ____
Address ____
City _________________________ **State** __________ **Zip** ___________________
Is patient attending school full or part time _______________________________

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