

## INSURANCE INFORMATION

**The information listed below is necessary for filing your insurance claims.**

**PATIENT INFORMATION:**

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Primary Insurance**

**EMPLOYEE/SUBSCRIBER INFORMATION:**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**EMPLOYER INFORMATION:**

Company Name \_\_\_\_\_  
Address \_\_\_\_\_

**INSURANCE CARRIER INFORMATION:**

Name of Carrier \_\_\_\_\_ Phone Number \_\_\_\_\_  
Address \_\_\_\_\_  
Policy, ID, or Contract Number \_\_\_\_\_ Group Name and/or Group No. \_\_\_\_\_

◆◆ **Is patient covered by another dental plan? If so, please complete the next section.** ◆◆

**Secondary Insurance**

**EMPLOYEE/SUBSCRIBER:**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Social Security Number \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

**EMPLOYER:**

Company Name \_\_\_\_\_  
Address \_\_\_\_\_

**INSURANCE CARRIER:**

Name of Carrier \_\_\_\_\_ Phone Number \_\_\_\_\_  
Address \_\_\_\_\_  
Policy, ID, or Contract Number \_\_\_\_\_ Group Name and/or Group No. \_\_\_\_\_