DENTAL **INSURANCE INFORMATION** **DATE**_____

****ALL INFORMATION MUST BE COMPLETED FOR PROPER FILING***

PATIENT NAME _____ DATE OF BIRTH _____

PRIMARY INSURED'S NAME_____**RELATIONSHIP**_____

COMPLETE HOME ADDRESS _____

CITY/STATE/ZIP_____

INSURED'S SS#_____**DOB OF INSURED**_____

EMPLOYER_____

DENTAL INSURANCE COMPANY_____

EFFECTIVE DATE OF INSURANCE _____

INS. CO. COMPLETE ADDRESS_____

CITY/STATE/ZIP_____

INS. CO. PH#_____**PLAN/GROUP #**_____

ID# IF DIFFERENT FROM SS#_____

PLEASE FILL OUT THE FOLLOWING IF YOU HAVE A SECONDARY DENTAL INSURANCE:

SECONDARY INSURED'S NAME _____**RELATIONSHIP**_____

COMPLETE HOME ADDRESS_____

CITY/STATE/ZIP_____

INSURED'S SS#_____**DOB OF INSURED**_____

EMPLOYER_____

DENTAL INSURANCE COMPANY _____

EFFECTIVE DATE OF INSURANCE_____

INS. CO. COMPLETE ADDRESS_____

CITY/STATE/ZIP_____

INS. CO. PH#_____**PLAN/GROUP #** _____

ID# IF DIFFERENT FROM SS#_____

OFFICE USE:

DATE CHECKED ON _____ *DATE CHECKED ON*_____
*PRIM LIFETIME MAX*_____ *SEC LIFETIME MAX*_____
*% PAID AT*_____ *% PAID AT*_____
*AMT USED*_____ *AMT USED*_____
*HOW PAYS*_____ *HOW PAYS*_____