INSURANCE INFORMATION

Patient Name: _____ Patient DOB: _____

PRIMARY DENTAL Insurance Company: _____

Mailing Address of Ins.
Co.:_____

Ins. Provider Service Phone Number: (_____) _____ - _____

Policy Holder's Name: _____ Date of Birth _____-_____-_____

Policy Holder's SSN or ID#:_____ Relationship to Patient: _____

Policy Holder's Employer: _____ Group #:_____

TO BE COMPLETED BY OFFICE:

Name of Representative:_____ Date Verified:_____

Effective Date: _____- _____- _____ % Paid:_____ Deductible:_____

Lifetime Max:_____ **Benefits Used: YES NO** Available Remaining Benefits: _____

Age Limit: _____ **Waiting Period: YES NO** Waiting Period Ends: _____

Continuation of Benefits: **YES NO** Coordination of Benefits Policy: _____

Payments: **Submit Monthly** or **Automatic Payments (Monthly) (Quarterly)**

SECONDARY DENTAL Insurance Company: _____

Mailing Address of Ins.
Co.:_____

Ins. Provider Service Phone Number: (_____) _____ - _____

Policy Holder's Name: _____ Date of Birth _____-_____-_____

Policy Holder's SSN or ID#:_____Relationship to Patient: _____

Policy Holder's Employer: _____ Group #:_____

TO BE COMPLETED BY OFFICE:

Name of Representative:_____ Date Verified:_____

Effective Date: _____- _____- _____ % Paid:_____ Deductible:_____

Lifetime Max:_____ **Benefits Used: YES NO** Available Remaining Benefits: _____

Age Limit: _____ **Waiting Period: YES NO** Waiting Period Ends: _____Continuation of Benefits: **YES NO**

Coordination of Benefits Policy: _____Payments: **Submit Monthly** or **Automatic Payments (Monthly) (Quarterly)**