

## 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)**