



**DENTAL INSURANCE INFORMATION**

Providing the following dental insurance information will assist us in the determination of your dental and orthodontic insurance benefit(s) that will be presented to you at the exam appointment. Without this information, our staff will not be able to accurately provide you with an estimated treatment fee at your first appointment.

***Please return this form along with your health history prior to your scheduled exam appointment in the enclosed self-addressed stamped envelope.***

Complete the following utilizing the information on your insurance card that provides your dental benefits. If patient is covered under two (2) insurances, please use the back of this form to provide the secondary coverage information.

PLEASE PRINT

\_\_\_\_\_  
PATIENT'S NAME Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
INSURED NAME Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

HOME ADDRESS OF INSURED \_\_\_\_\_

INSURED SOCIAL SECURITY # \_\_\_\_/\_\_\_\_/\_\_\_\_ HOME PHONE NUMBER \_\_\_\_\_

\_\_\_\_\_  
INSURANCE COMPANY PHONE NUMBER \_\_\_\_\_

GROUP # \_\_\_\_\_ ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

INSURED EMPLOYER \_\_\_\_\_ PHONE NUMBER \_\_\_\_\_

EMPLOYER ADDRESS \_\_\_\_\_ CITY \_\_\_\_\_ STATE \_\_\_\_\_ ZIP CODE \_\_\_\_\_

*I hereby authorize release of any information relating to this claim.*

\_\_\_\_\_  
Signature of Insured Date \_\_\_\_\_

**OVER**

