DENTAL INSURANCE

Patient's Name _____ Home Phone _____

Address _____ Date of Birth _____

Relationship to Primary Subscriber _____

Relationship to Secondary Subscriber _____

PRIMARY INSURANCE

Primary Subscriber _____

Address _____ Home Phone _____

_____ SS# _____

Date of Birth _____

Employer _____ Subscriber ID# _____

Insurance Company _____ Plan/Group# _____

Address to submit claim to _____

SECONDARY INSURANCE

Secondary Subscriber _____

Address _____ Home Phone _____

_____ SS# _____

Date of Birth _____

Employer _____ Subscriber ID# _____

Insurance Company _____ Plan/Group# _____

Address to submit claim to _____

Note: Pre-estimates are usually required for dental and/or surgical work in excess of $100. We cannot, however, submit the pre-estimate without this necessary form signed by you. Please bring your dental insurance card to your appointment.

Signature _____ Date _____