DENTAL INSURANCE INFORMATION

PRIMARY

Name of subscriber and relationship to patient:______________________________

Subscriber's Social Security#_____-____-_____ Date of Birth:__________________

Name of Employer & Address:____

Name of Insurance Company:____

Address:____

Telephone Number: (____) ____

Group Name or Number:____

Policy Number:____

SECONDARY

Name of subscriber and relationship to patient:______________________________

Subscriber's Social Security:# _____-_____-_____ Date of Birth: _______________

Employer Name & Address:____

Name of Insurance Company:____

Address:____

Telephone: (____) ____

Group Name or Number:____

Policy Number: ____