Patient Name: ______________________
Patient DOB: ______________________

Primary DENTAL Insurance:

__none __self __other
__spouse __child

Employer: ______________________________

Address: ________________________________

City ______________________Zip_________

Ins. Co: _________________________________

Claims address: __________________________

____

Phone: _________________________________

Member ID: ___________________________

Group #______________________________

Payer ID #_____________________________

Secondary DENTAL Insurance:

__none __self __other
__spouse __child

Employer: ______________________________

Address: ________________________________

City ______________________Zip__________

Ins. Co: _________________________________

Claims address: __________________________

____

Phone: _________________________________

Member ID: ____________________________

Group #_______________________________

Payer ID #_____________________________

Responsible party:

__self __other :________________________________(see information below)

(Please complete below if other than self or different residence than self)

Billing address: ____

City: _____________________ State: ______ Zip: ____________

Home: ___________________ Work: __________________ Mobile: __________________

Email: ____

(Please complete below if you are not the main employee on insurance policy OR if secondary insurance will be utilized)

SSN of insured/employee: ________________________

DOB of insured/employee: _________________________