Dental Insurance

Do you have dental insurance? **Yes** **No**
If Yes, please provide the following information.
Name of Insured: _____
Insured's Birth Date: _____
Insured's Address: _____
City:_____ State:_____ Postal Code:_____

Patient's Relationship to Insured: **Spouse** **Child**

Insured's Employer Name:
Employer's Address:
City:_____ State:_____ Postal Code:_____

Carrier Name:
Plan Name: _____
ID #: _____
Group #: _____
Insurance Company Phone Number: _____
Insurance's Address: _____
City:_____ State:_____ Postal Code:_____

Do you have Secondary Insurance? **Yes** **No**
If Yes, please provide the following information.

Name of Insured: _____
Insured's Birth Date: _____
Insured's Address: _____
City:_____ State:_____ Postal Code:_____

Patient's Relationship to Insured: **Spouse** **Child**

Insured's Employer Name: _____
Employer's Address: _____
City:_____ State:_____ Postal Code:_____

Carrier Name: _____
Plan Name: _____
ID #: _____
Group #: _____
Insurance Company Phone Number: _____
Insurance's Address: _____
City:_____ State:_____ Postal Code:_____

Patient Signature: _____ **Date Signed:**_____