Dental Insurance Form

Page 1

Policy Holders Primary Dental Insurance Information

We need your Dental Insurance information NOT your medical insurance information (they are different)

Are you covered under a dental insurance plan? *

(●) Yes ( ) No

Is the patient the dental insurance policy holder? *

( ) Yes (●) No

Please attach a picture of your dental insurance card

(if available)

Make sure the photo is in focus and not blurry.

Front of Dental Insurance Card

Drop files to attach, Use Camera, or browse

Back of Dental Insurance Card

Drop files to attach, Use Camera, or browse

Policy Holders First Name *

Policy Holders Last Name *

Policy Holders Birth Date *

__/__/____

Policy Holders SSN# *

___-__-____

Policy Holders Employer *

Dental Insurance Carrier *

Dental Insurance phone number *

(___) ___-____

(located on back of your dental insurance card)

ID / Member # *

Group # *

Plan *

Page 2

Policy Holders Secondary Dental Insurance Information

We need your Dental Insurance information NOT your medical insurance information (they are different)

Are you covered by a secondary dental insurance plan? *

( ) Yes ( ) No

Is the patient the secondary dental insurance policy holder? *

( ) Yes ( ) No

Please attach a picture of your Secondary dental insurance card

(if available)

Make sure the photo is in focus and not blurry.

Front of Secondary Dental Insurance Card

Drop files to attach, Use Camera, or browse

Back of Secondary Dental Insurance Card

Drop files to attach, Use Camera, or browse

Policy Holders First Name *

Policy Holders Last Name *

Policy Holders Birth Date *

__/__/____

Policy Holders SSN# *

___-__-____

Policy Holders Employer *

Dental Insurance Carrier *

Dental Insurance phone number *

(___) ___-____

(located on back of your dental insurance card)

ID / Member # *

Group # *

Plan *