

DENTAL INSURANCE INFORMATION

If you have Dental Insurance benefits, please submit information below prior to your initial visit.  
Completed forms can be faxed to (615) 373-4566.  
If you need assistance, please call (615) 373-4242.  
Thank you for allowing us to serve you.

SUBSCRIBER NAME : \_\_\_\_\_

SUBSCRIBER ID (usually SS#) : \_\_\_\_\_

PATIENT NAME : \_\_\_\_\_

RELATION TO SUBSCRIBER :    ☐ SELF            ☐ SPOUSE            ☐ CHILD            ☐ OTHER

INSURANCE CARRIER NAME : \_\_\_\_\_

INSURANCE CARRIER PHONE # : \_\_\_\_\_

EMPLOYER NAME : \_\_\_\_\_

STREET ADDRESS : \_\_\_\_\_

CITY, STATE, ZIP CODE : \_\_\_\_\_

PHONE # : \_\_\_\_\_

CONTACT : \_\_\_\_\_

GROUP PLAN : \_\_\_\_\_

GROUP # : \_\_\_\_\_

BENEFIT RENEWAL MONTH (usually January) : \_\_\_\_\_

PAYER ID : \_\_\_\_\_



MARK B. WHALEY, D.D.S.  
*Aesthetic & General Dentistry*