

DENTAL INSURANCE INFORMATION

PRIMARY CARRIER

INSURANCE COMPANY _____
GROUP NO. _____
EMPLOYER NAME _____
INSURED'S NAME _____
DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____
INSURED'S I.D. NO. _____
INSURED'S SOCIAL SECURITY NO. _____

SECONDARY CARRIER

INSURANCE COMPANY _____
GROUP NO. _____
EMPLOYER NAME _____
INSURED'S NAME _____
DATE OF BIRTH _____ RELATIONSHIP TO PATIENT _____
INSURED'S I.D. NO. _____
INSURED'S SOCIAL SECURITY NO. _____

ACCOUNT INFORMATION PERSON FINANCIALLY RESPONSIBLE

NAME _____ RELATIONSHIP TO PATIENT _____
SOCIAL SECURITY NO. _____ PHONE NUMBER _____
ADDRESS _____
CITY _____ STATE _____ ZIP _____
OCCUPATION _____ EMPLOYER'S NAME _____
ADDRESS _____
PHONE NUMBER _____

GETTING TO KNOW YOU

IS ANOTHER MEMBER OF YOUR FAMILY OR RELATIVE A PATIENT OF OURS?
NAME _____ RELATIONSHIP _____

YOU WERE REFERRED TO US BY _____

PERSON TO CONTACT IN AN EMERGENCY _____
PHONE NUMBER _____