

Patient's name: _____ Date: _____

If you have a dental insurance policy:

Responsible party's primary dental insurance policy:

Employee's name: _____ Birth date: _____

Employee's address: _____

Employee's phone: Home: _____ Work: _____ Cell: _____

Employee I D #: _____ Social security #: _____

Employer's name: _____

Employer's address: _____

Employer's phone: _____

Group policy name: _____ Group or union local number: _____

Plan type: Indemnity PPO DMO Retired Salary Hourly Other: _____

Insurance carrier: _____

Carrier address: _____

Carrier phone: _____

If you have a second insurance policy:

Responsible party's secondary dental insurance policy:

Employee's name: _____ Birth date: _____

Employee's address: _____

Employee's phone: Home: _____ Work: _____ Cell: _____

Employee I D #: _____ Social security #: _____

Employer's name: _____

Employer's address: _____

Employer's phone: _____

Group policy name: _____ Group or union local number: _____

Plan type: Indemnity PPO DMO Retired Salary Hourly Other: _____

Insurance carrier: _____

Carrier address: _____

Carrier phone: _____