

# Insurance Information

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## Patient Information

Patient Name

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## Insurance Type

Type of Plan

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## Primary Dental Insurance - Insurance Company

Insurance Company Name

Subscriber ID

Group #

## Primary Dental Insurance - Insured

Relationship to Patient

Name

Birth / SSN / License

Address

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## Primary Dental Insurance - Employer

Is the plan through an employer?

Employer Company Name

Employer Address

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## Secondary Dental Insurance - Insurance Company

Do you have secondary insurance you'd like to use?

Type of Plan

Insurance Company Name

# Insurance Information

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Subscriber ID

Group #

## Secondary Dental Insurance - Insured

Name

Relationship to Patient

Birth / SSN / License

Address

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## Secondary Dental Insurance - Employer

Is the plan through an employer?

Employer Company Name

Employer Address

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## Sign Form

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Date:

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