Dental Insurance Information

Date:_____

Patient Name: _____

Patient D.O.B: _____

Name of policyholder: _____

SS#: _____

Subscriber # :_____

Insured D.O.B: _____

Employer:_____

Name of Insurance Company: _____

Address of Insurance Company: _____

Group #: _____

Insurance 800 Telephone #: _____

For Office Use Only

Deductible:_____ **Paid @:**_____**%**

Lifetime Max:_____ **Amount Used:**_____

Age Limit:_____ **Charge Frequency:**_____

Name of Representative:_____