

Dental Insurance Information

Subscribers Name: _____ Birth Date: _____

Subscribers ID/ Social Security# _____

Primary Insurance Co: _____

Group# _____ Effective Date: _____

Ins. Co. Address: _____

Ins. Co. Phone# _____ Insured's Employer _____

Do You Have Dual Coverage? Yes or No (If Yes Complete Below)

Insured's Name: _____ Birth Date: _____

Insured's ID/ Social Security# _____

Secondary Insurance Co. _____

Group# _____ Effective Date: _____

Ins. Co. Address: _____

Ins. Co. Phone# _____ Insured's Employer: _____

As a courtesy, claims may be filed on my behalf.

Signed: _____ **Date:** _____