

Insurance Information Form

PATIENTS NAME _____ DATE _____

Insurance Company's Name _____

Address: _____ Phone# _____

Member's Name (Name of Insured): _____

Member's ID# _____ Group # _____

Insured Date of Birth: ___/___/___ Insured Social Security #: ___-___-___

In order to process claims for you or your family members, it is necessary that this questionnaire be completed and signed.

1. Do you have other employment? **Yes / No**. If yes, please indicate:

Employer's Name _____

Employer's Address _____

Employer's Phone Number _____

2. Is your spouse or any dependent child employed? **Yes / No**. If yes:

Name of Spouse _____

Employer's Name _____

Employer's Address _____

Employer's Phone Number _____

3. Are you, your spouse or children covered by any other dental coverage?

Yes / No. If yes:

Name of Insurance Company _____

Address _____

Phone Number _____

Name of Policy Holder _____

Policy Number _____ Effective Date _____

I/We certify that the above is true and correct and authorize any insurance carrier to furnish _____ Insurance Company with the information about the benefits or claim payment to which I/We are entitled.

Member's Signature

Date