

BENEFIT INFORMATION

Do you have dental insurance? Yes _____ No _____

PRIMARY INSURANCE

Patient Name _____ Phone () _____
Last First Initial
Patient SSN _____ DOB _____

Subscriber's name _____ Phone () _____
Last First Initial
Subscriber's SSN _____ DOB _____ Relation to Patient _____

Insurance Name _____ Phone () _____
Group # _____ Is it a PPO _____ HMO _____

SECONDARY INSURANCE

Subscriber's name _____ Phone () _____
Last First Initial
Subscriber's SSN _____ DOB _____ Relation to Patient _____

Insurance name _____ Phone () _____
Group # _____ Is it a PPO _____ HMO _____