



**INSURANCE INFORMATION**

**Please fill out information for each dental plan that the patient is covered under.**

1. Dental Insurance Company \_\_\_\_\_  
Toll Free Phone # \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Subscriber's Social Security # \_\_\_\_\_  
Subscriber's Date of Birth \_\_\_\_\_  
Employer \_\_\_\_\_  
Plan # \_\_\_\_\_  
Group # \_\_\_\_\_  
Claim's Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. Dental Insurance Company \_\_\_\_\_  
Toll Free Phone # \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Subscriber's Social Security # \_\_\_\_\_  
Subscriber's Date of Birth \_\_\_\_\_  
Employer \_\_\_\_\_  
Plan # \_\_\_\_\_  
Group # \_\_\_\_\_  
Claim's Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

3. Dental Insurance Company \_\_\_\_\_  
Toll Free Phone # \_\_\_\_\_  
Subscriber's Name \_\_\_\_\_ Relation to Patient \_\_\_\_\_  
Subscriber's Social Security # \_\_\_\_\_  
Subscriber's Date of Birth \_\_\_\_\_  
Employer \_\_\_\_\_  
Plan # \_\_\_\_\_  
Group # \_\_\_\_\_  
Claim's Address \_\_\_\_\_  
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