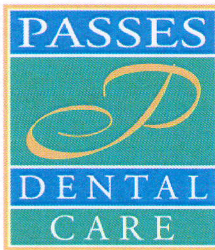

PLEASE COMPLETE THIS FORM FIRST SO WE CAN ALLOW ENOUGH TIME TO COMPLETE YOUR COMPLIMENTARY BENEFIT CHECK.

Primary Dental Insurance

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

____

Insurance Phone Number: ____________

Group Number: ____________

Insured's Name: ______________________________

Relation: ____________

Insured's Birthday: / /

Social Security # ______________________________

Insured Employer: ______________________________

Patients Birthday: / /

School Name if Patient is Attending: ____________
Full Time or Part Time *Please make sure your insurance has current records on your student status*

Secondary Dental Insurance

Insurance Co. Name: ______________________________

Insurance Co. Address: ______________________________

____

Group Number: ____________

Insured's Name: ______________________________

Relation: ____________

Insured's Birthday: / /

Social Security # ______________________________

Insured Employer: ____________