Insurance Information

Patient: Submitted: 4/24/2024

Patient Information

First Name | Last Name

Does the patient currently have ACTIVE dental insurance coverage? Yes [ ] No [ ]

(Returning Patients) Have there been any changes to your dental insurance since your last appointment? Yes [ ] No [ ]

****New patients** *with active dental insurance and* **returning patients with changes** *to dental insurance please complete the* **Primary Dental Insurance** *sections and* **Secondary Insurance** *sections (if applicable)*

Primary Dental Insurance

Insurance Company Information

Insurance Company Name
Insurance Company Phone Number
Type of Plan
Group #
Subscriber ID#

***If the Subscriber ID# is unknown, please provide the plan subscriber's Social Security number.**

Insured (Subscriber Information)

Employer Information

Is the plan through an employer? Yes [ ] No [ ]
Employer/Company Name

Secondary Dental Insurance

Do you have secondary insurance you'd like to use? Yes [ ] No [ ]

Insurance Company Information

Insurance Company Name
Insurance Company Phone Number
Type of Plan
Group #
Subscriber ID#

***If the Subscriber ID# is unknown, please provide the plan subscriber's Social Security number.**

Insured (Subscriber Information)

Insurance Information

Patient: Submitted: 4/24/2024

Employer Information

Is the plan through an employer? Yes [ ] No [ ]
Employer/Company Name

Sign Form

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status. (Read Electronic Record and Signature Disclosure)

I consent to use Electronic Records and Signatures: [ ]