

INSURANCE INFORMATION FORM

**IN ORDER TO FILE YOUR INSURANCE, ALL AREAS IN BOLD BELOW
MUST BE COMPLETED. DO NOT LEAVE ANY BLANKS. THANK YOU.**

Patient's full name AND date of birth: _____

Dental insurance company name: _____

Dental insurance company address: _____

Dental insurance company city, state & zip: _____

Dental insurance company phone number: _____ **Contact:** _____

Effective date: _____ Ortho lifetime max: _____ Deductible: _____ Waiting period: _____

Age limit? _____ Pay at what %? _____

Pays automatically? Monthly Quarterly Yearly Office must submit? Monthly Quarterly Yearly

Employer name: _____

Employer address: _____

Employer city, state & zip: _____

Employer phone: _____ **Insurance contact:** _____

Insurance members: Plan ID# _____ Group # _____

Policy # _____ Union # _____

Insurance dental group/plan name: _____

Employee name: _____ **Employee DOB:** _____

Employee ID# and/or social security #: _____

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