

INSURANCE INFORMATION

Date of Visit: _____

Patient Name: _____ **Patient's DOB:** _____

Policy Holder's Name: _____ **Date of Birth:** _____

Policy Holder's Address: _____

City: _____ **State:** _____ **Zip:** _____

Relationship to Patient: _____ **Phone Number:** _____ **Cell/Home**

Social Security #: _____ **Subscriber ID #:** _____

Employer: _____ **Group #:** _____

Dental Ins. Co.: _____ **Ins. Co. Phone:** _____

For SECONDARY Insurance Only:

Policy Holder's Name: _____ **Date of Birth:** _____

Policy Holder's Address: _____

City: _____ **State:** _____ **Zip:** _____

Relationship to Patient: _____ **Phone Number:** _____ **Cell/Home**

Social Security #: _____ **Subscriber ID #:** _____

Employer: _____ **Group #:** _____

Dental Ins. Co.: _____ **Ins. Co. Phone:** _____

*******FOR OFFICE USE ONLY*******

Ins Co: _____ **Phone #:** _____ **Spk w/:** _____

ID#: _____ **Grp#:** _____ **%:** _____ **Lifetime Max:** _____

SUB/SP/DEP CH/ Age Limit: _____ **Deductible:** _____ **Waiting Period:** _____ **Amt used:** _____

AM AQ ASA/M Q SA Mail Claims to: _____

Can we FAX CLAIMS? Fax #: _____

SECONDARY Insurance: Standard Nondup

Ins Co: _____ **Phone #:** _____ **Spk w/:** _____

ID#: _____ **Grp#:** _____ **%:** _____ **Lifetime Max:** _____

SUB/SP/DEP CH/ Age Limit: _____ **Deductible:** _____ **Waiting Period:** _____ **Amt used:** _____

AM AQ ASA/M Q SA Mail Claims to: _____

Can we FAX CLAIMS? Fax #: _____

NPI #: 1962623819

Tax ID #: 465630289