Dental Insurance Form

If we do not receive or have the following information on your day of service, you will be expected to pay in full. Due to HIPPA laws and time, we cannot call insurance companies for this information. Please contact the policy holder's HR department for this information.

Primary Dental Insurance

Policy Holder's Full Name:

Policy Holder's Date of Birth:

Policy Holder's Place of Employment:

Insurance Company Name:

Insurance Company Address (to submit claims to, usually a PO Box):

Insurance Company Phone Number:

Group Number:

Subscriber ID Number:

Family Members On This Policy:

Secondary Insurance

Policy Holder's Full Name:

Policy Holder's Date of Birth:

Policy Holder's Place of Employment:

Insurance Company Name:

Insurance Company Address (to submit claims to, usually a PO Box):

Insurance Company Phone Number:

Group Number:

Subscriber ID Number:

Family Members On This Policy: