Patient Name: _____

Date of Birth: _____

Thank you for providing your dental insurance card!
By providing a copy of your most recent insurance card, we're able to verify your current benefits and submit claims to the correct and current address. **Please note: Not all treatment may be billable to insurance due to insurance limitations**.

Primary Dental

_____
Name of Policy Holder

_____
Date of Birth of Policy Holder

_____
Name of **Primary** Dental Insurance Plan

_____
Name of Employer who provides benefits (if this is an individual plan, not employer sponsored, write individual)

_____
Primary Dental Group Number

_____
Primary Policy Number,Subscriber Number,or ID Number (if no unique ID is listed, the SS# of the policy holder is needed to verify dental benefits)

_____
Date Policy Was Effective

_____
Is this patient covered by more than one dental policy? **If yes, please complete the full right column**. ⟶ This will ensure accurate coordination of benefits with all plans involved.

Please list the name and date of birth of all patients covered under this plan.

_____ _____

_____ _____

Secondary Dental

_____
Name of Policy Holder

_____
Date of Birth of Policy Holder

_____
Name of **Secondary** Dental Insurance Plan

_____
Name of Employer who provides benefits (if this is an individual plan, not employer sponsored, write individual)

_____
Secondary Dental Group Number

_____
Secondary Policy Number,Subscriber Number,or ID Number (if no unique ID is listed, the SS# of the policy holder is needed to verify medical benefits)

_____
Date Policy Was Effective

_____
Is this patient covered by a third dental policy? If yes, please complete an additional form. This will ensure accurate coordination of benefits with all plans involved.

Please list the name and date of birth of all patients covered under this plan.

_____ _____

_____ _____

_____ _____

I accept this dentist's statement and authorize the release of information relating hereto. I authorize payment directly to the dentist named on the claim. I understand that I am responsible for all cost of dental treatment not paid by insurance.
No insurance? No problem, please sign this form so we're sure we asked and you acknowledge responsibility for all charges.

Signature Patient/Parent: _____ Date: _____