

**Insurance Information Form**

**Patient:** \_\_\_\_\_ **Record #** \_\_\_\_\_

**Relationship to Employee:** \_\_\_\_\_ **Self**    \_\_\_\_\_ **Spouse**    \_\_\_\_\_ **Child**    \_\_\_\_\_ **Other**

**Employee/Subscriber Name:** \_\_\_\_\_

**Employee/Subscriber Social Security Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Employee/Subscriber Date of Birth:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

**Employer (Company) Name and Address:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Insurance Company Name, Address and Phone Number:** \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Group Number (If applicable):** \_\_\_\_\_

**Policy Anniversary Date:** \_\_\_\_\_

**Do you have a copy of your dental benefit booklet?**    \_\_\_\_\_ **Yes**            \_\_\_\_\_ **No**

**Do you know the deductible amounts and/or percentage of reimbursement?**    \_\_ **Yes**    \_\_ **No**

**If you have a copy of your dental benefit booklet, please bring it with you to your appointment with your assigned dental care provider for verification by our staff. You are also requested to bring a copy of your insurance form with all pertinent employee information completed and signed where appropriate. Failure to provide necessary information may result in delay of treatment and/or denial of insurance coverage.**

**Thank you for your cooperation.**