

**INSURANCE INFORMATION**  
**(please complete in full)**

**Primary Insurance**

Dental Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company Phone \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Subscriber ID# or SSN \_\_\_\_\_

Coverage: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Family \_\_\_\_\_

**Secondary Insurance**

Dental Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Insurance Company Phone \_\_\_\_\_ Group # \_\_\_\_\_

Subscriber Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Relationship to Patient \_\_\_\_\_

Subscriber ID# or SSN \_\_\_\_\_

Coverage: Self \_\_\_\_\_ Spouse \_\_\_\_\_ Family \_\_\_\_\_