DENTAL INSURANCE INFORMATION AND UPDATE

Please provide as much information below as possible about your current dental insurance or if you have recently changed from the insurance we currently have on file.

Date:

Patient's Name: Date of Birth:

Subscriber's Name (If Different from Above): Date of Birth:

Relationship to Patient:

Subscriber's Address:

Subscriber's Phone: Email:

Subscriber's Social Security Number:

Dental Insurance Company Name:

Dental Insurance Company Address:

Phone #:

Subscriber's Member ID #:

Group #: Effective Date:

FOR OFFICE USE ONLY

Verified By: Date:

LTM: Used:

%:

Age Limit: Waiting Period: ❑ YES ❑ NO Ends:

Medically Necessary Clause?:

Work in Progress Covered?:

Coordination of Benefits:

Payment Schedule: ❑ Monthly ❑ Quarterly ❑ Bi-annually ❑ Annually

Payment Type: ❑ Automatic ❑ Manual

Faxback Requested?: ❑ YES ❑ NO

Name of Rep and Reference #:

Notes: