

Please provide us with all the information below. Your information will be kept in strict confidence and is used only for your insurance benefit determination.

## Section 1. Patient Information

First Name \_\_\_\_\_ Last Name \_\_\_\_\_ Date of Birth (*month/day/year*) \_\_\_\_\_

Best Contact Phone Numbers: \_\_\_\_\_

## Section 2. Insured/Employee Information

Insured Name \_\_\_\_\_ Date of Birth (*month/day/year*) \_\_\_\_\_

Insurance ID Number (or SSN if no ID) \_\_\_\_\_

Insured Employer Name \_\_\_\_\_ Group Number \_\_\_\_\_

Insured Home Zip Code \_\_\_\_\_ Insured Home Phone Number \_\_\_\_\_

## Section 3. Insurance Company Information

Name of Insurance Company \_\_\_\_\_

Address \_\_\_\_\_

Phone Number \_\_\_\_\_

## Section 4. Insurance Usage Information

Have you used the current year dental insurance benefit?

Yes  No  Not Sure

If Yes, When? \_\_\_\_\_

What Treatment Was Received? \_\_\_\_\_