Insurance & Financial Information

PATIENT NAME: _____ DOB: _____

Please help us submit accurate and timely claims by providing the information below to the best of your knowledge:

□ **Primary** Dental Insurance Provider: _____

Primary Subscriber Name: _____DOB: _____

Social Security Number: _____Group Number: _____

Subscriber Number or Member ID: _____

□ **Secondary** Dental Insurance Provider: _____

Primary Subscriber Name: _____ DOB: _____

Social Security Number: _____Group Number: _____

Subscriber Number or Member ID: _____

□ No dental insurance coverage at this time

□ I do not have my dental insurance provider details available now. Please…

- □ wait for my call. I will contact you with my insurance info at a later time.
- □ contact my general dentist for information regarding my dental insurance.

Do you have a total budget in mind for this treatment? __Yes __No

If yes, please explain:_____

_____

_____

Person Completing Form (please print): _____Date _____