Today's Date_____

Sponsor of Plan Name _____

Sponsor Address _____

_____

Primary Dental Insurance Company _____

Mailing Address for Dental Claims _____

_____

Member/Subscriber Name _____ Date of Birth _____/_____/_____

Relationship to subscriber ❑ self ❑ spouse ❑ dependent

Group Number _____Subscriber ID Number _____

Secondary Dental Insurance Company _____

Mailing Address for Dental Claims _____

_____

Member/Subscriber Name _____ Date of Birth _____/_____/_____

Relationship to subscriber ❑ self ❑ spouse ❑ dependent

Group Number _____Subscriber ID Number _____

Full payment is expected at the time of service, unless prior arrangements have been made. As a courtesy, we are happy to submit insurance forms on your behalf. In order to do this, we must have your correct insurance information on file. Please read your policy carefully. We strive to provide the most appropriate quality treatment for our patients. Some or all of the service we provide may not be a covered benefit. Please be aware of your insurance plan's limitations, exclusions and plan maximums. The entire account balance remains your responsibility.