

**Please bring this completed form to your consultation visit.**

## INSURANCE INFORMATION

Please fill out the following information and **ALSO** provide us with a completed dental claim form and/or a photocopy of the front and back of your **DENTAL/ORTHODONTIC** insurance card.

Please do **not** list medical insurance information.

Patient Name:
Today's Date:
Name of Dental/Orthodontic Insurance Plan:
Name of Policy Holder:
Policy Holder's Employer:
Policy Holder's Social Security #:
Policy Holder's Date of Birth:
Group #:
Effective Date of Policy:
Lifetime Maximum Benefits:
Coverage to Age:
Amount of Yearly Deductible:
Mail Claims to:
Insurance Customer Service Phone #: