Name of Patient: _____

Date of Birth: _____

Date Verified: _____

PRIMARY DENTAL COVERAGE

PLACE OF EMPLOYMENT OF INSURED:
_____
Address of Employer:
_____
Employer's Telephone Number:
_____
PRIMARY INSURED'S NAME:
_____
Primary Insured's Birthdate: _____
SSN: _____
Patient's Relationship to Insured:_____
INSURANCE COMPANY NAME:_____
Insurance company address:_____
Telephone #: _____
Group #: _____

Ortho Coverage? Yes _____ No _____
Lifetime Maximum: $_____
Payable at _____%
Deductible: $_____

Effective Date: _____
Lifetime Max Met: _____
Age Limit: _____
Deductible Met: _____
Monthly _____ Quarterly _____ Auto _____ As Filed _____
Payable on Fee Schedule _____ Initial _____ Balance _____
Pay Provider _____ Verified by _____
Spoke with _____