DENTAL INSURANCE INFORMATION SHEET

To be filled out by patient or parent/guardian:

DATE_____

PATIENT_____DOB_____

INSURED/EMPLOYEE_____DOB_____

ADDRESS OF EMPLOYEE_____ZIP CODE_____

SS#/ID#_____

EMPLOYER_____

DENTAL INSURANCE CO_____

PHONE #_____GROUP #_____

To be filled out by office staff:

MAX $_____ ____%

DEDUCTIBLE$_____ EFFECTIVE DATE_____

AGE LIMIT_____STUDENT STATUS_____

WAITING PERIOD_____

HAS ANY BENEFIT BEEN USED? YES NO HOW MUCH?_____

HOW DO YOU PAY_____

DOES POLICY HAVE NON-DUP CLAUSE?_____

WILL YOU PAY IF BRACES ARE ALREADY PLACED? YES NO

- **MAIL CLAIMS TO**:_____

  Address_____

  City, State, Zip_____

MISC INFORMATION_____

WHO DID YOU SPEAK TO?_____