Primary Dental Insurance

Cardholder's Name: ____

Cardholder's SS #: ____

Cardholder's DOB: ____

Cardholder's Address: ____

City:________________________________ State:________ Zip:____________

Employer Name (Who Provides Ins:)____

Cardholder's Signature: ____________________________________ Date:__________________

OFFICE USE ONLY

Phone Confirmed Date:____/____/______

Insurance Service Representative:

Name: ______________________________

Phone #: ________________________________

Patient Eligible Date:____/____/_____

Lifetime Max: $ ______________________

Deductible: __________________________

(One Time OR Annual)

Percentage Payable: _________________%

Age Limit:____________________________

Additional Comments: _________________