# Dental Insurance Information Form

*Policyholder's Date of Birth and Social Security Number are needed to verify benefits*

Patient's Legal Name: _____ Date of Birth: _____

Policyholder's Legal Name: _____ Date of Birth: _____

Policyholder's SSN: _____

Dental Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone Number: _____

Subscriber ID#: _____ Group#: _____

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OFFICE USE ONLY

Orthodontic Lifetime Maximum & Deductible:

$_____

Percent Payable: _____

Age Limit & Adult Coverage: _____

Waiting Period: _____

Billing Info: Automatic Monthly Quarterly Six Months

Completed by: _____ Date completed: _____

Recon: _____