



**IF YOU WOULD LIKE US TO SUBMIT A CLAIM TO YOUR INSURANCE CARRIER, PLEASE FILL OUT  
THE INFORMATION BELOW**

***Dental Insurance Information***

Subscriber \_\_\_\_\_ Patient \_\_\_\_\_  
Subscriber S.S.N. \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Subscriber Birthdate \_\_\_\_\_ Patient Birthdate \_\_\_\_\_

**Name and Address of Insurance Company**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Insurance Co. Phone Number \_\_\_\_\_  
Employer \_\_\_\_\_  
Group Number \_\_\_\_\_