Insurance Information Form

Patient(s) Name(s):	
Birthdate(s):	
Address:	
City & State:	Zip code:

Member's Information (Parent/Holder of Insurance):

Member/Subscriber Name:		
*****SSN# or Insurance ID#:**		*****Birthdate:**
Address *(If different than patient)*:		
City & State:		Zip code:
Phone number:	Email:	

Employer Information (Place of Employment):

Employer's Name:	
Address:	
City & State:	Zip code:

Dental Insurance Carrier:

Insurance Carrier's Name:	
Address:	
City & State:	Zip code:
Phone number:	**Plan/Group #:**

☐ **Primary** ☐ **Secondary**

****** You will need to bring a photo ID and your dental insurance card to your appointment. We require a copy of each. If you do not have a dental insurance card you will need to get the above information <u>prior</u> to your appointment or <u>you will be required to pay at time of service</u>. Thank you. ******

*Authorization for direct payment to Children's Dentistry Group, LLC:

X____ Date:________________

(Signature required in order for Children's Dentistry Group, LLC to submit to your insurance carrier.)

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