## Insurance Information

**(Please present your insurance card(s) at the initial exam for verification)**

Patient(s) Name: ______________________________________________

Date of Birth: ________________________________________________

**Primary Dental / Orthodontic Insurance:**

Name of Insured: _____________________________ Relation to Patient: ____________

Date of Birth: __________________ Employer: _________________________________

Insurance Company: ______________________________________________________

Insurance Phone Number: __________________________ SSN/ID: __________________

Group Number: _____________________ Policy Number: _________________________

**Secondary Dental / Orthodontic Insurance:**

Name of Insured: _____________________________ Relation to Patient: ____________

Date of Birth: __________________ Employer: _________________________________

Insurance Company: ______________________________________________________

Insurance Phone Number: __________________________ SSN/ID: __________________

Group Number: _____________________ Policy Number: _________________________

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