DENTAL POINT

PATIENT INSURANCE INFORMATION FORM

Patient Information:

Full Name: _____ Date of Birth: _____
Address: _____ Phone: _____
Email: _____

Insurance Information:

1. Do you have dental insurance? If yes, please provide the following information:
   Insurance Company: _____ Phone: _____
   Policy Holder's Name: _____ Policy Number: _____
   Group Number: _____ Effective Date: _____
   Employer: _____
2. If you have secondary insurance, please provide the following information:
   Insurance Company: _____ Phone: _____
   Policy Holder's Name: _____ Policy Number: _____
   Group Number: _____ Effective Date: _____
   Employer: _____
3. Please provide any additional insurance information that may be helpful:

I authorize the release of any information necessary to process insurance claims. I understand that I am responsible for all charges incurred regardless of insurance coverage.

Signature: _____ Date: _____

Please complete this form before your appointment and bring it with you to the dental office. This information will help us process your insurance claims and ensure that you receive the maximum benefits available to you.