Dental Insurance

Name of Patient: ____

Signature of Patient/Parent________________________________

Date:__________________

Patient has dental insurance coverage with: (check box)

Delta Dental of______________ __

Horizon __

Other __

If coverage is through Delta or Horizon, please complete the following:

Name of Subscriber: _____________________

Birthdate of Subscriber: __________________

Subscriber ID#: _______________ Plan #: ________________

Name of Patient: ________________________

Birthdate of Patient: _____________________

Relationship to Insured: Self __ Spouse __ Dependent Child __