# 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 prior to your appointment or you will be required to pay at time of service. 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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