Felton Dental Center Date:_____

Insurance Information

PRIMARY Dental Insurance

Name of Policy Holder _____
Policy Holder's Social Security No._____
Date of Birth: _____
(if self, then please disregard

Relationship to patient: (circle one)
Self Parent Spouse Other
If other, please explain_____

Name of Insurance _____
Group/Employer: _____

ID Number_____or Group Number_____
(which ever applies in your case)

Please also provide us with your card so we can make a copy for your file

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SECONDARY Dental Insurance (*if applicable, please complete this portion*)

Is the Policy Holder same as above? ___yes ___no
If different, then provide:
Policy Holder Name _____
Social Security No._____Date of Birth _____

Relationship to patient: (circle one)
Self Parent Spouse Other
If other, please explain_____

Name of Insurance _____
Group/Employer: _____

ID Number_____or Group Number_____
(which ever applies in your case)