CHAMBERLAIN
DENTAL HEALTH

Insurance Information Form

Primary Dental Insurance Information

Please fill out completely

Today's date ___/___/___

Patient's Relation to insured: ☐ Self ☐ Patient's Spouse ☐ Patient's Parent ☐ Other:_____

Name of Insured:_____ Is the insured a patient Y☐ N☐
last first middle

Insured's address: _____
Street Address City State Zip

Insured's phone:(___)_____ Insured's date of birth___/___/___

Insured's Social Security #:_____

Insured's Employer's Name:_____Employer's Phone#:_____

Employer's address:_____
Street address City State Zip

Insurance Plan Name:_____ Insurance phone: (___)_____

Insurance Plan Address:_____
Street address City State Zip

Group Number:_____ Other information:_____

Secondary Dental Insurance Information

Patient's Relation to insured: ☐ Self ☐ Patient's Spouse ☐ Patient's Parent ☐ Other:_____

Name of Insured:_____ Is the insured a patient Y☐ N☐
last first middle

Insured's address: _____
Street Address City State Zip

Insured's phone:(___)_____ Insured's date of birth___/___/___

Insured's Social Security #:_____

Insured's Employer's Name:_____Employer's Phone#:_____

Employer's address:_____
Street address City State Zip

Insurance Plan Name:_____ Insurance phone: (___)_____

Insurance Plan Address:_____
Street address City State Zip

Group Number:_____ Other information:_____

IF YOUR DENTAL INSURANCE PLAN CHANGES, IT IS YOUR RESPONSIBILITY TO NOTIFY OUR OFFICE.