

### Dental Insurance Information

1. **Do you have dental insurance?**

☐ Yes    ☐ No

2. **Primary Dental Insurance Carrier:**

(e.g., Delta Dental, MetLife, Aetna)

3. **Policy Holder's Full Name:**

(Name of the person who carries the insurance)

4. **Policy Holder's Date of Birth:**

(MM/DD/YYYY)

5. **Relationship to Policy Holder:**

☐ Self    ☐ Spouse    ☐ Child    ☐ Other: \_\_\_\_\_

6. **Employer (if applicable):**

7. **Member ID or Policy Number:**

8. **Group Number (if applicable):**

### Secondary Dental Insurance

(If you have additional coverage)

9. **Do you have secondary dental insurance?**

☐ Yes    ☐ No

10. **Secondary Insurance Carrier:**

11. **Policy Holder's Full Name:**

12. **Policy Holder's Date of Birth:**

13. **Relationship to Policy Holder:**

☐ Self    ☐ Spouse    ☐ Child    ☐ Other: \_\_\_\_\_

14. **Employer (if applicable):**

15. **Member ID or Policy Number:**

16. **Group Number (if applicable):**