Dental Insurance Information

If you cannot fill out the entirety of this section, please email a photo of your insurance card to: bethanygeymandds@gmail.com

Do you have dental insurance? * ◯ Yes ◯ No

Who is your dental insurance company? _____

Name of Insured: _____ (Last) _____ (First) ____ (MI)

Insured's Birth Date: _____

ID #: _____ **Group #:** _____

Insured's Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Insured's Employer Name: _____

Employer Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____ (Address 1) _____ (Address 2)

_____ (City) _____ (State) _____-____ (Zip Code)

If you do not have a member ID#, your insurance will use your SSN: _____

Insurance Company Phone Number: _____

Responsible Party Name and Phone Number: *

_____

_____

Do you have a secondary insurance? ◯ Yes ◯ No

For secondary insurance, please list any information you have including the insurance plan name, subscriber, date of birth of the subscriber, member#, group#, and a telephone#:

_____

_____

Response Date: _____