Brennan Dental
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Dental Insurance Information

(1) Carrier

_____ _____

Name (if Delta Dental, specify *which* Delta Dental, e.g., Washington, California, etc.)

Customer Service Phone Number

Member ID# _____

Group # _____

If you have dental coverage from more than one insurance carrier, please provide this same information for each additional carrier on the back of this sheet, and indicate which policy is primary and which is secondary.

(2) Policy Holder / Subscriber

_____ _____

Full legal name

Date of Birth

(3) Besides the subscriber, who is covered by this policy?

Name

Date of Birth

_____ _____

_____ _____

_____ _____

_____ _____

I understand that I am responsible for providing accurate, current insurance information and that if the information I provide is incorrect, I am responsible for paying all treatment fees and submitting charges to the correct plan for reimbursement.

_____ _____

Signature

Date