

## Dental Insurance

Do you have dental insurance?      Y      N

Are you the policy holder?      Y      N

Primary Policy holders First and Last Name: \_\_\_\_\_

Primary Policy holders Date of Birth: \_\_\_\_\_ SS#: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Is this your Primary or Secondary Insurance? \_\_\_\_\_

Relationship to the policy holder: \_\_\_\_\_

Primary Policy holders address: \_\_\_\_\_

Primary Policy holder's employer, if insurance is through them: \_\_\_\_\_

Carrier Name (which insurance company): \_\_\_\_\_

Plan Name: \_\_\_\_\_

Member ID (for MetLife, it is the policy holders SSN): \_\_\_\_\_

Group #: \_\_\_\_\_

Insurance Companies Phone No. (back of the card): \_\_\_\_\_

Insurance Companies Address (back of the card): \_\_\_\_\_

Please take a picture of the **front and back** of your **insurance card(s)** and your **state ID** and please text us at (301)377-8306 or email: [records@prostho-dent.com](mailto:records@prostho-dent.com).

If you have secondary insurance, please notify us so we can give you another form for you to fill out.