Dental Insurance Claim Form

1. Patient Information

Full Name

Date of Birth

Gender

Address

Phone Number

Relationship to Insured

2. Policy Holder Information

Policy Holder Name

Policy Number

Insurance Company

Group Number

Employer Name

3. Dentist Information

Dentist Name

Dentist License Number

Phone

Address

4. Treatment Information

Date of Service	Tooth #	Procedure Code	Description	Fee Charged

Total Fee Charged

Amount Paid by Patient

5. Authorization & Signature

Patient/Guardian Signature

Date

Dentist Signature

Date