REGIONAL DENTAL CENTER

505 Pelham Road South
Jacksonville, AL 36265
(256) 435-4482

PATIENT INSURANCE FORM

Patient Name: _____ DOB: _____ SSN: _____

Address: _____

Phone Number: Home _____ Cell _____ Other _____

Copy of Insurance Card _____ Copy of Driver's License _____

PRIMARY INSURANCE

Insurance Company: _____

ID#: _____ Group#: _____

Primary Policyholder: _____ DOB: _____ SSN: _____

Primary Policyholder Employer: _____

SECONDARY INSURANCE

Insurance Company: _____

ID#: _____ Group#: _____

Primary Policyholder: _____ DOB: _____ SSN: _____

Primary Policyholder Employer: _____

I verify that all information provided is correct

_____ _____
Patient Date