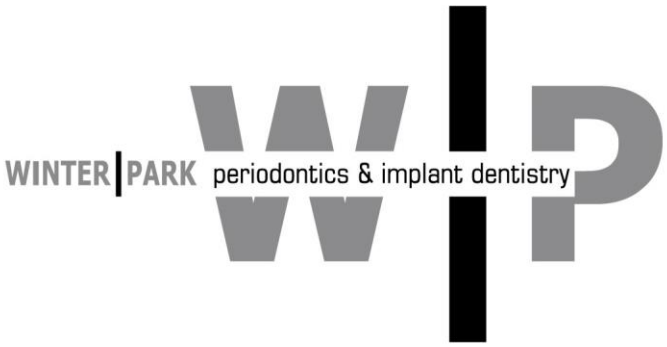

PIN_____ DATE_____

DENTAL INSURANCE INFORMATION

Patient's Name:_____ Birthdate:_____

Sex: Male ☐ Female ☐

Subscriber's Name:_____ Birthdate:_____

Relationship of Subscriber to Patient:_____

Employer of the Subscriber:_____

Subscriber's Social Security:_____

Subscriber's ID:_____

Group Number:_____

Insurance Name:_____

Insurance Address:_____

_____

Phone Number:_____