THOMAS W. DUNN D.D.S. CAGS
INSURANCE INFORMATION

We will be using this information to provide you with an accurate estimate of your benefits. Please help us serve you better by having this information ready for us when you come in for your initial consultation.

THANK YOU!

PRIMARY INSURANCE:

Policy Holder: _____
Social Security No.: _____
Date of Birth: _____
Name of Employer: _____
Dental Insurance Plan: _____
Group or Contract No.: _____
Billing Address & Telephone No.: (This should be listed on your insurance card)

_____

_____

If there is an additional dental plan, please complete the following:

SECONDARY INSURANCE:

Policy Holder: _____
Social Security No.: _____
Date of Birth: _____
Name of Employer: _____
Dental Insurance Plan: _____
Group or Contract No.: _____
Billing Address & Telephone No.: (This should be listed on your insurance card)

_____

_____

TO BEST HELP US COMPLETE YOUR FINANCIAL PROFILE DURING YOUR VISIT, PLEASE CONTACT YOUR INSURANCE CUSTOMER SERVICE REPRESENTATIVE FOR EACH INSURANCE AND ASK:

1. IF YOU HAVE ORTHODONTIC BENEFITS ON YOUR DENTAL PLAN. Y or N

2. HOW IS IT PAID OUT? WHAT PERCENTAGE OF BILLED CHARGES ARE PAID AND UP TO WHAT LIFETIME MAXIMUM?

_____

_____

Thank you for your assistance!