Date: _____

Please fill out all of the information below regarding your **DENTAL** insurance. We do not need any medical insurance information.

Primary Insurance:

* Dental Insurance Company _____

* Address_____

* City_____ State_____ Zip _____

* Dental Insurance Company Phone Number_____

* Policy Holder's Name_____

* Policy Holder's Date of Birth_____

* Policy Holder's SS or Member ID # _____

* Group Number_____

* Employer's Name_____

* Address_____

* City_____ State_____ Zip_____

* Employer's Phone Number_____

If you have any questions and or concerns please feel free to contact our office.

Thank you,

Dr. Erhart and Staff

* REQUIRED FIELDS – We must have complete information in order to check and submit insurance claims on your behalf.