CASTLE PEAK
DENTAL

Insurance Information: PLEASE COMPLETE ALL INFORMATION

Patients Full Name:_____DOB:_____
(as listed on insurance card)

Subscriber Full Name:_____DOB:_____
(as listed on insurance card)

Member ID / OR Social Security Number of subscriber:_____

Patient Member ID (if different than above):_____

Group / Plan Number:_____

Patient /Subscriber Address as listed on file with your insurance company:_____

Please Circle One: Employer Plan /OR Individual Plan

If Employer Plan – Name of Employer:_____

Insurance Company Name:_____

Claims Mailing Address:_____

Member or Provider Phone Number (as listed on the back of your insurance card):_____

We will make every attempt to have your benefits verified before your appointment, therefore it is important that we receive COMPLETE and ACCURATE information a minimum of 48 hours prior to your appointment.