

Date: _____

Lindner Dental Account #: _____

Dental Insurance Information

Please note: Lindner Dental Associates, P.C participates with and submits claims to all Delta Dental Insurance Companies and Northern New England Benefit Trust. Please ask what your estimated out-of-pocket expense will be at the time of each appointment. All incomplete dental insurance information forms will be returned and cannot be processed.

Insurance Company's Name _____

Customer Service Phone # _____

Claims Address _____

Group #: _____ ID# _____

Is this a new insurance company? YES / NO

Does this information replace the information we have on file? YES / NO

Is this insurance company in addition to the insurance on file? YES / NO

Subscriber Name _____
(name of individual insurance is through)

Subscriber SS# _____
(required unless all services are paid in full at time of appointment)

Subscriber DOB: _____ Subscriber's Employer _____

Names of patients covered by this insurance & their relationship to subscriber:

Patient address: _____ Home phone _____
_____ work / cell # _____

*****PLEASE ATTACH COPY OF FRONT & BACK OF INSURANCE CARD*******