

Dental Insurance Claim Form

Patient Information

Full Name

Date of Birth

Address

City

ZIP/Postal Code

Phone Number

Email

Insurance Information

Insurance Company

Policy Number

Group Number

Policy Holder Name

Treatment Information

Date of Service

Treating Dentist

Description of Treatment

Tooth Number(s)

Procedure Code(s)

Total Fee Charged

Amount Claimed

Authorization

Patient/Guardian Signature

Date