Duxbury Dental Associates

New/Change of Dental Insurance

****In order to properly submit all dental claims, all the information below must be supplied. Failure to do so will result in the patient being charged the full balance owed.****

Patient Name:

Subscriber Name:

Subscriber Address: (if different from Patient)

Subscriber Phone: (if different from Patient)

Subscriber SSN:

Subscriber DOB: (MM/DD/YYYY)

Subscriber Employer:

Dental Insurance Company Name:

Dental Insurance State: (e.g. Delta of NY, Northeast Dental, BC/BS of TN)

Dental Insurance Member ID #:

Dental Insurance Group #:

Please List All Individuals Covered Under the Subscriber's Plan:

Do you have any additional dental coverage? (if yes, please list all subscriber information below)