

Date: _____

Gerber Dental Account # _____

Dental Insurance Information

Please note: Gerber Dental Group will accept and submit to most insurance companies. We participate with NE Delta Dental, Delta USA and Delta Premier Plans. Gerber Dental does not guarantee benefits or payment from your insurance company. All incomplete dental insurance information forms will be returned and will not 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 on file? YES/NO
Is this insurance company in addition to the insurance on file? YES/NO

Subscriber Name _____
(Person's name insurance is through)

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

Subscriber DOB: _____ Subscriber Employer _____

Name and Date of Birth of patients covered by this insurance & their relationship to subscriber:

Patient address: _____ Home phone # _____

_____ Work/Cell # _____

*****Please attach a copy of the front and back of your Insurance Card*****