

Daniel H. Markham, D.M.D.
Insurance Information Form

Primary Insurance Plan

Name of Insured: _____ Soc. Sec # _____

Insured's Date of Birth: _____ Date of Employment: _____

Insured's Employer: _____

Employer's Address: _____

City: _____ State: ____ Zip Code: _____

Employer's Phone: _____ Fax: _____

Name of Insurance Plan: _____

Claims Address: _____

City: _____ State: ____ Zip Code: _____

Ins. Phone : _____ Fax: _____

Patient ID# _____ Group # _____

Does another member of your family have dental insurance?

Yes: ____ No: ____

If yes, which plan is primary for the children?

This plan: ____ Spouse's Plan: ____

Signature of Insured (If Minor, Parent or Legal Guardian) Date: _____