Walter D. Fain, D.D.S.
Dental Insurance Information

Date_____ Your Name _____

Your Social Security #_____ Your Carrier ID #_____
If different from your SS#

Primary Insurance Information

Name of Insured _____

Relationship to Patient: Self_____ Spouse _____ Child _____ Other _____

Insured Social Security # _____ Insured Carrier ID # _____
If different from SS#

Insured Birth Date _____

Employer or Policy Sponsor _____

Group ID #_____

Insurance Company _____
Insurance Company Address
Street or Box # _____

City, State, Zip _____

Secondary Insurance Information

Name of Insured _____

Relationship to Patient: Self_____ Spouse _____ Child _____ Other _____

Insured Social Security # _____ Insured Carrier ID # _____
If different from SS#

Insured Birth Date _____

Employer or Policy Sponsor _____

Group ID #_____

Insurance Company _____
Insurance Company Address
Street or Box # _____

City, State, Zip _____