ERBES
FAMILY DENTAL CENTER

- Full Mouth Rehabilitation
- TMJ/Occlusal Disorders
- Cosmetic Dentistry
- Implant Prosthetics

Dental Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ ZIP _____

Insurance Company _____ Group# _____ Policy /ID# _____

Address of Ins. Co. _____ City _____ State _____ ZIP _____

Do you have any additional insurance? ☐ Yes ☐ No If yes, complete the following:

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____ City _____ State _____ ZIP _____

Insurance Company _____ Group# _____ Policy /ID# _____

Address of Ins. Co. _____ City _____ State _____ ZIP _____