Dental Insurance

Primary Insurance

Name of Insured _____
Relationship to patient _____
Subscriber's Birthdate _____
Soc. Sec. # _____
Employer _____
Date Employed _____
Occupation _____

Insurance Company _____
Address _____
Phone _____
Group # _____
Employee/Cert. # _____
Deductible _____
Amount already used _____
Max. Annual Benefit _____

Additional Insurance

Name of Insured _____
Relationship to patient _____
Subscriber's Birthdate _____
Soc. Sec. # _____
Employer _____
Date Employed _____
Occupation _____

Insurance Company _____
Address _____
Phone _____
Group # _____
Employee/Cert. # _____
Deductible _____
Amount already used _____
Max. Annual Benefit _____

Staff Use Only:

Patient was asked for referrals by: Staff Member: Date: Card to Share Card:

Hobbies, Interests, Events, Conversations:

Visual Auditory Kinesthetic

Values Ask: What is important about your dental experience?

Rules Ask: How do you want to be treated here?

Details Ask: When I explain something to you, do you like a lot of explanation?

Big Picture Only Ask: Do you prefer fewer details?

Triangle