South Austin Oral Surgery - Dental Insurance Documentation Worksheet

Patient Information (Will go in ADA Dental Claim Form Sections #18-23)	
Patient Name:	
Patient Address:	
Relationship to Policyholder:	□ Self □ Spouse □ Dependent Child □ Other
Date of Birth:	Gender: □ M □ F □ U

Dental Benefit Plan Information (Will go in ADA Dental Claim Form Section #3)	
Company/Plan Name:	
Address:	

Policyholder/Subscriber Information (Will go in ADA Dental Claim Form Section #12-17)	
Policyholder Name:	
Policyholder Address:	
Policyholder ID:	
Plan/Group Number:	Employer Name:
Policyholder DOB:	Policyholder Gender: □ M □ F □ U

Date/Time	Notes:
Representative	
Reference #	

Date/Time	Notes:
Representative	
Reference #	

Date/Time	Notes:
Representative	
Reference #	

Date/Time	Notes:
Representative	
Reference #	