PROSTHO.
ENDO.
Bethesda | Rockville | Vienna

Dental Insurance

Do you have dental insurance? Y N

Are you the policy holder? Y N

Primary Policy holders First and Last Name: _____

Primary Policy holders Date of Birth: _____ SS#:_____-_____-_____

Is this your Primary or Secondary Insurance? _____

Relationship to the policy holder: _____

Primary Policy holders address: _____

Primary Policy holder's employer, if insurance is through them: _____

Carrier Name (which insurance company): _____

Plan Name: _____

Member ID (for MetLife, it is the policy holders SSN): _____

Group #: _____

Insurance Companies Phone No. (back of the card): _____

Insurance Companies Address (back of the card): _____

Please take a picture of the **front and back** of your **insurance card(s) and your state ID** and please text us at (301)377-8306 or email: records@prostho-dent.com.

If you have secondary insurance, please notify us so we can give you another form for you to fill out.