Tedford Dental

7562 S. University Blvd. Suite J
Centennial, Co 80122
303.770.8278
303.770.8279, fax
tedforddental.com
finance@tedforddental.com

Dental Insurance Information

Responsible Party (Policy Holder/Subscriber): (Same as patient :_____)

Name as seen on insurance card_____

Address_____

City_____State/Zip_____

Good Contact phone number_____

Male / Female Date of Birth: _____

SS#/ Subscriber ID: _____

Primary Dental Insurance:

Relationship to the insured: Self / Spouse / Child / Other_____

Name of Dental Insurance Co: _____

Claims mailing address_____

Provider/Customer Service Phone Number: _____

Group # _____

Employer of Subscriber:_____

SS# (if other than Subscriber)_____

Date of Birth (if other than Subscriber)_____

Secondary Dental Insurance:

Relationship to the insured: Self / Spouse / Child / Other_____

Name of Dental Insurance Co: _____

Claims mailing address_____

Provider/Customer Service Phone Number: _____

Group # _____

Employer of Subscriber:_____

SS# (if other than Subscriber)_____

Date of Birth (if other than Subscriber)_____

Please bring a copy of all insurance cards to your first visit. It is our office policy to work closely with your insurance company and, as a courtesy; we will keep all of your insurance information current and bill them electronically. All treatment plans provided are based on your insurance company's estimate of benefits provided to our office. As the insured, you are ultimately responsible for any and all charges that are incurred.