Dental Claim Form Sample

This sample dental claim form demonstrates how to accurately fill out patient information for insurance processing. It highlights key sections such as patient details, dental procedures, and provider information to ensure a smooth claim submission. Using a **dental claim form sample** helps avoid common errors and expedites reimbursement.

1. Patient Information			
Patient Name	Emily Johnson	**Date of Birth**	03/14/1990
Gender	Female	**Phone Number**	(555) 123-4567
Patient ID	EMJ19900314	**Relationship to Subscriber**	Daughter
Address	456 Oak Ave Unit 10 Springfield, IL 62704		
2. Insurance Information			
Subscriber Name	Michael Johnson	**Subscriber ID/Policy #**	MJ110789
Insurance Carrier	Delta Dental	**Group Number**	DD-20345-A
3. Dental Procedure Information			
Date of Service	**Procedure Code**	**Tooth Number/Surface**	**Fee Charged**
2024-05-25	D1120 (Prophylaxis-Child)	Primary	$75.00
2024-05-25	D1208 (Fluoride Application)	All	$35.00
		Total Fee	**$110.00**
4. Provider Information			
Dentist Name	Dr. Amanda Lee	**License Number**	DN112233
Practice Name	Springfield Family Dental	**Phone**	(555) 987-6543
Provider Address	789 Main St Springfield, IL 62704		
5. Authorization			
Patient/Guardian Signature	Emily Johnson	**Date**	2024-05-25