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### Dental Insurance Information

Are you currently eligible for any dental insurance benefits?  Yes  No

Insured's Name \_\_\_\_\_

Relationship to you \_\_\_\_\_

Insured's Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's Social Security Number \_\_\_\_\_  
Month Date Year

Insured's Address \_\_\_\_\_

\_\_\_\_\_  
Telephone ( ) \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

\_\_\_\_\_  
Telephone ( ) \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Policy Number or Group Number \_\_\_\_\_

*If applicable, please provide information for secondary insurance coverage:*

Insured's Name \_\_\_\_\_

Relationship to you \_\_\_\_\_

Insured's Birth Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Insured's Social Security Number \_\_\_\_\_  
Month Date Year

Insured's Address \_\_\_\_\_

\_\_\_\_\_  
Telephone ( ) \_\_\_\_\_

Insured's Employer \_\_\_\_\_

Employer's Address \_\_\_\_\_

\_\_\_\_\_  
Telephone ( ) \_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Policy Number or Group Number \_\_\_\_\_