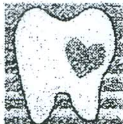

Park Drive Dental Centre Inc.

DENTAL INSURANCE INFORMATION

Patient Name: ____ DOB: _______________

Primary Insurance Coverage:

Name of Insured: ____________________________________ DOB: ______________________

Employer: ____ID/Certificate#: _________________

Insurance Company Name: ____

Group/Plan/Policy#:__________________________________ Division#: ___________________

Secondary Insurance Coverage:

Name of Insured: ____________________________________ DOB: ______________________

Employer: ____ID/Certificate#: _________________

Insurance Company Name: ____

Group/Plan/Policy#:__________________________________ Division#: ___________________