ADA Claim Form Dental

ADA CLAIM FORM DENTAL

Complete all sections in full. Incomplete forms may delay processing.

Name: _____ Date completed: _____ dd / mm / yyyy

Date of birth: _____ dd / mm / yyyy Record / MRN number: _____

Address

Phone: _____ Email: _____

Emergency contact: _____ Relationship and phone: _____

ABOUT YOUR ADA CLAIM DENTAL

Reason for completing this form

Have you completed this form before?

◯ Yes ◯ No ◯ Not sure

Relevant history

Current medication, supplements and allergies

PLEASE CONFIRM

- ☐ The information I have given is accurate and complete
- ☐ I will tell the practice if anything changes
- ☐ I have read and understood the privacy notice

FOR OFFICE USE ONLY

Received by: _____ Date received: _____ dd / mm / yyyy

Action taken: _____ Reference number: _____

Signature and date

Print name: _____