

---

Centre Dental—Dr John Shi  
139 Centre St, Suite 306  
New York, NY 10013  
Ph: 888-842-7558  
Fax: 212-925-2923 /201-255-0148

---

***Insurance Eligibility Form***

*Please provide us with all the information below. All information will be kept in strict confidence and is used for your insurance benefit determination only.*

***Your Information***

Legal Name: Last \_\_\_\_\_ First \_\_\_\_\_

Date of Birth \_\_\_\_\_

Contact Phone \_\_\_\_\_

***Insured/Employee Information***

Insured Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Insured Soc Sec No. \_\_\_\_\_ Insurance ID# \_\_\_\_\_

Insured Company Name: \_\_\_\_\_ Group No \_\_\_\_\_

Insured Home Zip Code \_\_\_\_\_

***Insurance Company Information***

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

Insurance Co. Address; \_\_\_\_\_

Insurance Co. Phone No. \_\_\_\_\_