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**Dental Insurance**

I/We have dental insurance \_\_\_\_\_ yes \_\_\_\_\_ no

Name of primary insurance company \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_

Group # \_\_\_\_\_

Name of insured \_\_\_\_\_

Insured's social security # \_\_\_\_\_

Do you have insurance with more than one company? \_\_\_\_\_

Name of secondary insurance company \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone # (\_\_\_\_) \_\_\_\_\_

Group # \_\_\_\_\_

Name of insured \_\_\_\_\_

Insured's social security # \_\_\_\_\_