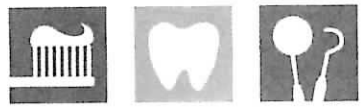

Duluth Dental Associates
Van Nguyen, D.M.D

INSURANCE VERIFICATION

Patient:_____ **DOB**:_____

Subscriber:_____ **Member ID**: _____

Subscriber DOB: _____

Insured Employer_____ **Group #** _____

Insurance Company: _____ **Phone #**: _____

Mailing Address: _____

_____

_____

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Fax: 678-417-7071
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