INSURANCE INFORMATION

Today's Date_____

Patients Name_____

Address: _____

Home Phone # _____ Work Phone #_____ Cell Phone #_____

Patients SS#_____D.O.B of Patient_____ E-Mail_____

If Patient is over 18 – Are you a Full Time Student? YES / NO Name and Address of School:

_____ Semesters attending _____

Insured's name_____ Patient's Relationship to Insured_____

Insured's SS#_____ D.O.B. of insured _____

Insured's Employer_____ Phone #_____

Insurance Company_____ Phone #_____

Group#_____ Policy #_____Employee #_____

_____

OFFICE USE

Effective Date Of Insurance_____ Dependent Coverage_____
Student Coverage_____ Benefit Year– Calendar or _____

Deductible $_____Family Deductible $_____Max Allowance $_____
Deductible Apply to Preventive Services YES / NO Carry Over YES / NO_____

Preventive Services_____% Cleanings/Per Year_____ FLX /Yr & Age Limit_____
Full Mouth / Pan X-Ray_____ BWX _____Sealants Age_____

Basic_____% Perio _____% Endo _____% Oral Surgery _____%
Posterior resins downgraded : Yes / No Full Fee or Fee Schedule allowed?
Major _____% Inlays/Onlays _____% Crowns_____ % Implant _____%

Implant Crown _____% Ortho _____% D0140 _____% D2940 _____% D2960 _____%

D4381 _____% D9110 _____% D9911_____% D9940 _____%

Pre Determination Mandatory……. …Yes No Want X-rays? ….. Yes No
Waiting period on Major work……Yes No _____
Missing Tooth Clause……Yes No

Verified By_____Date_____