Date________________

DENTAL INSURANCE INFORMATION

(Please note we are not a participating or contracted provider with any insurance plan)

Name of Patient:__________________________________Birthdate:________________________

Patient's SS#:____

Insured's Name:__________________________________Birthdate:________________________

Insured's SS#:___________________________Employer:________________________________

Insurance Company Name:____

Claims Address:__________________________________Phone:___________________________

City:____State:__________Zip:__________________

Contact Person:______________________________Group/Policy#:________________________

**************************** **FOR OFFICE USE ONLY BELOW** ****************************

Individual Yr. Max $__________________ Family Maximum $___________________

Individual Deductible $________________ Family Deductible $__________________

Effective Date:_______________________ Deductible applied___________________

Payment: Percentage of UCR__________ or Fee Schedule______________________

PREVENTIVE:____________________________

Initial Oral Exam: Interval___________________
Periodic Oral Ex: Interval___________________
Prophy: Interval____________________________
Fluoride: Interval___________________________
Perio Pro (4910): Interval___________________
PAN: Interval_______________________________
BWS: Interval______________________________
Oral Sedation?_____Y_____N
Sealants: Age limit?_____Perm Molar?_____Y_____N

PERIO:___________________________________

Endodontics (Root Canals)____________________
Prosthodontics/Crowns_______________________
Replacement Interval________________________
Prosthodontics/Bridges - Covers Replacement for Teeth Ext. prior to Coverage?_____Y_____N
Prosthodontics/Partials & Dentures____________
Missing tooth clause?_____Y_____N

BASIC COVERAGE:________________

ORAL SURGERY_________________

MAJOR:___________________________

ORTHODONTICS:_________________Ortho Max $____________________Age limit?_________________