Date:_____

INSURANCE POLICY HOLDER INFORMATION:

Name of Insured Employee:_____

Employer:_____Effective date of coverage:_____

Insured Social Security or member #:_____Birthdate:_____

Name of Dental Insurance Company:_____

Address:_____

Phone: ( )_____Group Number:_____

Who is covered under this policy?_____

Is there any other dental insurance coverage for any of the family members covered under this policy?
Yes/No *If there is other coverage, please ask for an additional form*

INSURANCE COVERAGE BREAKDOWN: (for office use only)

Calendar Year or Fiscal Year (circle one)

Requires Pre-determination? Yes No Suggest _____

Deductible: Indiv._____ Family:_____Applies to Prev.?_____

Yearly Max:_____Remaining:_____

Fee Schedule or Percentage (circle one) IF Secondary – Do you coordinate?_____

Preventitive:_____% 2 times a year or Once every six months?

Restorative:_____% Sealants:_____%
Up to What age? _____

Endodontics:_____%
Last Pano?_____

Periodontics:_____% Perio Maint? _____ Last BWX?_____
Freq?_____

Oral Surgery:_____%

Crown & Bridge:_____% Replacement?_____Missing tooth clause?_____

Dentures & Partials: Removable_____% Fixed_____%

TMJ: _____%

Implants: _____% If **NO** do they pay alternate benefit? _____

Orthodontics:_____% Max:_____

Spoke to:_____Confirmed by :_____
See Attached _____