

INSURANCE INFORMATION
(Please fill only top portion)

PATIENT NAME _____ DOB _____

INSURED NAME _____ DOB _____

INSURED SOCIAL SECURITY _____

INSURED EMPLOYER _____

INSURANCE COMPANY _____ PHONE# _____

GROUP OR POLICY # _____

(This portion for office use only)

EFFECTIVE DATE _____ FAMILY OR INDIVIDUAL

ANNUAL MAXIMUM \$ _____

DEDUCTIBLE PER PERSON \$ _____ FAMILY DEDUCTIBLE \$ _____

BENEFIT YEAR-----CALENDAR OR FISCAL

PREVENTATIVE _____% _____DED

BASIC _____% _____DED

MAJOR _____% _____DED

SEALANT _____% _____AGE LIMIT

PERIODONTICS _____%

ENDODONTICS _____%

FREQUENCY / LIMITATIONS

CLEANINGS _____

LAST PROPHY/BW/EXAM _____

BITEWINGS _____

EXAMS _____

FMX _____

LAST FMX _____

WAITING PERIOD ON MAJOR WORK? _____

PRE-TREATMENT ESTIMATE REQUIRED OR RECOMMENDED \$ _____ & UP

MISSING TOOTH CLAUSE? _____

5 YEAR REPLACEMENT RULE? _____

OCCLUSAL GUARDS COVERED? _____

MAILING ADDRESS _____ PAYOR ID _____

FAX # _____

INSURANCE REP _____ VERIFIED BY _____ DATE _____