

DENTAL INSURANCE INFORMATION

DATE _____

PATIENT NAME _____

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ PHONE _____

INS. CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

DO YOU HAVE ANY ADDITIONAL INSURANCE? YES NO IF YES, COMPLETE THE FOLLOWING

NAME OF INSURED _____ RELATIONSHIP TO PATIENT _____

BIRTHDATE _____ SOCIAL SECURITY NUMBER _____

NAME OF EMPLOYER _____ WORK PHONE _____

ADDRESS OF EMPLOYER _____ CITY _____ STATE _____ ZIP _____

INSURANCE COMPANY _____ GROUP # _____ INS. PHONE _____

INSURANCE CO. ADDRESS _____ CITY _____ STATE _____ ZIP _____

FOR OFFICE USE ONLY

DATE _____ INITIALS _____ CONTACT _____

INSURANCE EFFECTIVE DATE _____

MAXIMUM \$ _____ BENEFITS USED TO DATE \$ _____ DEDUCTIBLE \$ _____

PREVENT _____ %

BITEWINGS	6 MOS.	12 MOS.	YEAR	FMX/PAN	EVERY	MOS.	YRS.
PROPHY	6 MOS.	12 MOS.	YEAR	SEALANTS	EVERY	MOS.	YRS. TO AGE
EXAM	6 MOS.	12 MOS.	YEAR	FLOURIDE	EVERY	MOS.	YRS. TO AGE

BASIC	_____ %	ENDO	BASIC MAJOR
MAJOR	_____ %	PERIO	BASIC MAJOR
		OS	BASIC MAJOR

FREQUENCY ON RELINE? _____

WAITING PERIOD ON MAJOR WORK?	YES	NO	
MISSING TOOTH CLAUSE?	YES	NO	
CALENDAR YEAR?	YES	NO	
PRE-TREATMENT REQUIRED?	YES	SUGG.	AMOUNT _____
REPLACEMENT?	_____		
TMJ?	YES	NO	