MY INSURANCE VERIFICATION FORM

Arnold Dentistry would like to Welcome you and your family to our office. To help our office better serve you, we ask that you, the patient, take an active part in knowing what your insurance benefits are.

Prior to your appointment, please locate your insurance card and call the member services number on the back. Below is a list of questions that our office needs answered in order for our office and you to better understand your insurance benefits.

Without this information, we will be unable to process your treatment plan, if needed, with the proper fees and/or co-payments.

DATE ________________

INSURED NAME __________________________ *PATIENT NAME _______________________________*

DOB ________________________ *DOB _____________________*

SS# _________________________ *SS#_______________________*

EMPLOYER ______________________________________

INSURANCE CO ___________________________________ *MAILING ADDRESS _______________________________*

PHONE NUMBER _________________________________ *________________________________*

ID# ____ *CITY, ST ZIPCODE ________________________________*

GROUP# ____

QUESTIONS YOU NEED TO ASK:

Is my policy a PPO or HMO plan? ________________________ (we DO NOT accept HMO/DHMO plans)

Is my policy calendar year or fiscal year? _____________________ *Effective date of policy ___________________*

What is my yearly deductible? $_______ Have I met that deductible? Yes or No Is there a family deductible? $_______

Does the deductible apply to my Exams and Cleanings? Yes or No

What is my yearly maximum? $_______ How much do I have remaining of that maximum? $________

What percentage are my Preventative services covered at? ________% Is the yearly deductible applied? Yes or No

What percentage are my Basic services covered at? ________%

What percentage are my Major services covered at? ________%

What category do these services fall under?

Endodontics (root canals): Basic or Major   Periodontics: Basic or Major   Oral Surgery: Basic or Major

Do I have any waiting periods on my policy? Yes or No   If yes, when will it be satisfied? ____________________

Do I have a missing tooth clause? Yes or No

How many examinations am I allowed a year? ________ Do they have to be 6 months apart? Yes or No

How many cleanings am I allowed a year? ________ Do they have to be 6 months apart? Yes or No

Are Bitewing radiographs allowed once or twice a year? ___________________

How often can I have a Panorex or Full Mouth radiographs taken? ____________________________

Do I have a history of a Panorex or Full Mouth radiographs? _________________________________

Do I have Adult Fluoride coverage? Yes or No If yes, how often? _______________________

Is there Fluoride coverage for children? Yes or No If yes, how often? _________ Up to what age? __________

Is there any sealant coverage? Yes or No If yes, up to what age? ____________

Are Resin fillings downgraded to Silver fillings? Yes or No

Are Build Ups covered (code D2950)? Yes or No Are Gingivectomy's covered (code D4211)? Yes or No

Are TMJ appliances covered (code D7880)? Yes or No Are Occlusal Guards covered (code D9940)? Yes or No

What is the replacement period on Crowns, Bridges and Dentures? ____________________years

Are Crowns and/or Bridges paid on the Preparation date or Seat date? ___________________________

Do I have Implant coverage? Yes or No   Do I have Implant Crown coverage? Yes or No

Is a Bone Replacement Graft covered (code D7953)? Yes or No

Is a Full Mouth Debridement covered (code D4355?) Yes or No Is Arestin covered (code D4381)? Yes or No

How often is Scaling & Root Planning covered (code D4341)? _________________

Do I have Adult Orthodontic coverage? Yes or No Do I have Dependent Orthodontic coverage? Yes or No

If yes, up to what age? ______ What is the Orthodontic Maximum? $__________ Paid at what %? _________%

Is payment for Orthodontics paid according to length of time of treatment? Yes or No

If No, how is payment made? ______________________________

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