DENTAL INSURANCE INFORMATION

Name of **Primary** Dental Insurance: _____ Phone # ____/____/_____
Address _____
Group # _____ Member (ID#) _____ Effective Date ____/____/_____
Name of Insured: _____ DOB: ____/____/_____
Employer: _____

Name of **Secondary** Dental Insurance: _____
Address _____ Phone # ____/____/_____
Group # _____ Member (ID#) _____ Effective Date ____/____/_____
Name of Insured: _____ DOB: ____/____/_____
Employer: _____

ASSIGNMENT & RELEASE OF INFORMATION: I hereby authorize my insurance benefits to be paid directly to the dentist and I am financially responsible for services not insured. I further authorize the dentist to release any medical or dental information requested.

Signature: _____ Date: ____/____/_____

Date:		Effective Date:		Calendar Year:	
Deductible:	$	Family Deductible:	$	Max Benefit:	$
Coordination of Benefits: ❒ Yes ❒ No		Age Limit:		Student Age:	
Waiting Period: ❒ 6 months ❒ 12 months					

Missing Tooth Clause? ❒ Yes ❒ No			**Frequency**	**Limitations**
PREVENTIVE	**%**	**Deduct.**		
Exam				
FMX/Pano				
BWX's/PA				
Prophy				
Fluoride				
Sealants				
BASIC	**%**	**Deduct.**		
Post Comp			**Reduce to amalgam fees?** ❒ Yes ❒ No	
Perio				
Endo				
Oral Surgery				
Debridement				
Perio Maintenance				
NO_2				
MAJOR	**%**	**Deduct.**	**Replacement**	
Crown				
Bridges				
Dentures				
Mouthguard				

Eligible Family Members:	***Date of Birth***