

# INSURANCE COVERAGE INFORMATION

Today's Date \_\_\_\_\_ Patient's Appointment Date \_\_\_\_\_

Insured's Name \_\_\_\_\_ Insd's. DOB \_\_\_\_\_ SS # \_\_\_\_\_

Covered Spouse/Dependents \_\_\_\_\_

Employer \_\_\_\_\_

Insurance Co. Name \_\_\_\_\_ Electronic Payor # \_\_\_\_\_

Dental Claims Mailing Address \_\_\_\_\_  
\_\_\_\_\_

Group # \_\_\_\_\_ Spoke with: \_\_\_\_\_ Eff. Date Of Coverage \_\_\_\_\_

Yearly Max \$ \_\_\_\_\_ Deductible: Per Person \$ \_\_\_\_\_ Per Family \$ \_\_\_\_\_ Deductible Been Met? Y/N

Benefits Remaining This Plan Yr. \$ \_\_\_\_\_ Ins. Plan Year \_\_\_\_\_

**Preventative** % \_\_\_\_\_ Ded? Y/N Includes: \_\_\_\_\_

**Basic** % \_\_\_\_\_ Ded? Y/N Includes: \_\_\_\_\_

**Major** % \_\_\_\_\_ Ded? Y/N Includes: \_\_\_\_\_

Frequency: Exams \_\_\_\_\_ Cleanings \_\_\_\_\_ Bitewing X-Rays \_\_\_\_\_ Full Mouth Series or  
Panoramic X-Ray \_\_\_\_\_

Flouride % Coverage? \_\_\_\_\_ Age Limit? \_\_\_\_\_ Frequency: \_\_\_\_\_

Sealant % Coverage? \_\_\_\_\_ Age Limit? \_\_\_\_\_ Frequency: \_\_\_\_\_

Root Planing (4341) % Coverage? \_\_\_\_\_ Frequency: \_\_\_\_\_ Max # of Quads per visit? \_\_\_\_\_

**ORTHODONTIC COVERAGE:** % \_\_\_\_\_ Ded? \_\_\_\_\_ Lifetime Max \$ \_\_\_\_\_ Age Limit? \_\_\_\_\_

Pays Monthly or Quarterly? (circle) Submit or Automatic Payments? (circle)

Do you reduce posterior composite fillings to amalgam rates? Y/N Missing Tooth Clause? Y/N

Is there TMJ/Bruxism (9940) coverage under dental insurance plan? Y/N If Yes, what is max? \$ \_\_\_\_\_

Space Maintainers covered @ \_\_\_\_\_ % Age Limit? \_\_\_\_\_

Major Services Replacement Clause? \_\_\_\_\_

Waiting Periods? \_\_\_\_\_

Do you Coordinate Benefits if you're a Secondary Ins. Carrier? Y/N Std. COB/Non-Dup Clause? (circle)

Other Exclusions: \_\_\_\_\_