

PATIENT INSURANCE INFORMATION (PRIMARY)

Policy holder's name: _____
Insurance Company: _____
Plan Policy # _____ Certificate/ID # _____

EDI Yes No Assignment Yes No
Fee Guide: _____
Plan Year: _____
Annual Detectable \$ _____
Family Detectable \$ _____

Coverage Breakdown

Plan Max \$ _____

Basic	Major	X-Rays	Misc
Plan Max \$ _____	Plan Max \$ _____	Pan (02601) _____	Scale units _____
Coverage _____%	Coverage _____%	P.A (02111) _____	Fluoride 6 9 12
Endo _____%	Crowns/bridge _____%	B.W (02144) _____	Polish 6 9 12
Perio _____%	Ortho _____%		Recall 6 9 12
	Dentures _____%		Oral Hyg Ins. _____
			Occl. Adjust (16511) <input type="checkbox"/> Yes <input type="checkbox"/> No
			Perio Irrigation (42831) <input type="checkbox"/> Yes <input type="checkbox"/> No
			Adult Polish (11101) <input type="checkbox"/> Yes <input type="checkbox"/> No
			Comp on Molars <input type="checkbox"/> Yes <input type="checkbox"/> No
			Np Exam (01103) _____

Notes:

PATIENT INSURANCE INFORMATION (SECONDARY)

Policy holder's name: _____
Insurance Company: _____
Plan Policy # _____ Certificate/ID # _____

EDI Yes No Assignment Yes No
Fee Guide: _____
Plan Year: _____
Annual Detectable \$ _____
Family Detectable \$ _____

Coverage Breakdown

Plan Max \$ _____

Basic	Major	X-Rays	Misc
Plan Max \$ _____	Plan Max \$ _____	Pan (02601) _____	Scale units _____
Coverage _____%	Coverage _____%	P.A (02111) _____	Fluoride 6 9 12
Endo _____%	Crowns/bridge _____%	B.W (02144) _____	Polish 6 9 12
Perio _____%	Ortho _____%		Recall 6 9 12
	Dentures _____%		Oral Hyg Ins. _____
			Occl. Adjust (16511) <input type="checkbox"/> Yes <input type="checkbox"/> No
			Perio Irrigation (42831) <input type="checkbox"/> Yes <input type="checkbox"/> No
			Adult Polish (11101) <input type="checkbox"/> Yes <input type="checkbox"/> No
			Comp on Molars <input type="checkbox"/> Yes <input type="checkbox"/> No
			Np Exam (01103) _____

Notes:

