PATIENT INSURANCE INFORMATION (PRIMARY)

Policy holder's name: _____

Insurance Company: _____

Plan Policy # _____ Certificate/ID # _____

Coverage Breakdown

Plan Max $ _____

EDI ❑Yes ❑No Assignment ❑Yes ❑No

Fee Guide: _____

Plan Year: _____

Annual Detectable $ _____

Family Detectable $ _____

Basic

Plan Max $ _____

Coverage _____%

Endo _____%

Perio _____%

Major

Plan Max $ _____

Coverage _____%

Crowns/bridge _____%

Ortho _____%

Dentures _____%

X-Rays

Pan (02601) _____

P.A (02111) _____

B.W (02144) _____

Misc

Scale units _____

Fluoride 6 9 12

Polish 6 9 12

Recall 6 9 12

Oral Hyg Ins. _____

Occl. Adjust (16511) ❑Yes ❑No

Perio Irrigation (42831) ❑Yes ❑No

Adult Polish (11101) ❑Yes ❑No

Comp on Molars ❑Yes ❑No

Np Exam (01103) _____

Notes:

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PATIENT INSURANCE INFORMATION (SECONDARY)

Policy holder's name: _____

Insurance Company: _____

Planl Policy # _____ Certificate/ID # _____

Coverage Breakdown

Plan Max $ _____

EDI ❑Yes ❑No Assignment ❑Yes ❑No

Fee Guide: _____

Plan Year: _____

Annual Detectable $ _____

Family Detectable $ _____

Basic

Plan Max $ _____

Coverage _____%

Endo _____%

Perio _____%

Major

Plan Max $ _____

Coverage _____%

Crowns/bridge _____%

Ortho _____%

Dentures _____%

X-Rays

Pan (02601) _____

P.A (02111) _____

B.W (02144) _____

Misc

Scale units _____

Fluoride 6 9 12

Polish 6 9 12

Recall 6 9 12

Oral Hyg Ins. _____

Occl. Adjust (16511) ❑Yes ❑No

Perio Irrigation (42831) ❑Yes ❑No

Adult Polish (11101) ❑Yes ❑No

Comp on Molars ❑Yes ❑No

Np Exam (01103) _____

Notes:

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