DENTAL INSURANCE INFORMATION

Please write clearly and legibly Today's Date_____

PRIMARY DENTAL INSURANCE:

Patient's Name _____

Patient's S.S. Number_____-____-_____ OR Insurance ID Number_____

Insured Person's Name:_____ DOB_____/_____/_____

Insured's S.S. Number_____-_____-_____ OR Insurance ID Number_____

Insured Person's Employer_____

Insurance Carrier Name_____

Insurance Carrier Address_____ State_____ Zip_____

Insurance Carrier Phone Number_____ Plan Group Number _____

SECONDARY DENTAL INSURANCE:

Insured Person's Name:_____DOB_____/_____/_____

Insured's S.S. Number_____-_____-_____OR Insurance ID Number_____

Insured Person's Employer_____

Insurance Carrier Name_____

Insurance Carrier Address_____ State_____ Zip_____

Insurance Carrier Phone Number_____ Plan Group Number _____

(For office use only)

Date: **Rep:**

Eff. Date: **GROUP #**

Max: **Cal Yr / Benefit Yr.**

Perio Hx/Notes: 4341 txt dates

Max Used:

Max Remaining:

Ded: **Met/Not Met**

Fees: UCR SCH. Max. ALLOWABLE **Implant Coverage:**

Prev %
Basic %
Major %

Freq. Limits:

Waiting periods:

Coordination: