TODAY DATE_____ YOUR NAME _____

PAYER ID#_____

INSURANCE _____

INSURANCE PHONE #_____

SUBSCRIBER _____

PATIENT _____

SS # _____ DOB _____/ _____/_____

GROUP NAME AND _____

EFFECTIVE DATE _____

YEARLY MAXIMUM_____

HOW MUCH IS SPENT THIS YEAR _____ TODAY DATE_____

CALENDAR YEAR _____ FISCAL YEAR_____

DEDUCTIBLE_____

PREVENTIVE_____

BASIC_____

MAJOR_____

WAITING PERIOD _____

ACCEPT SIGNATURE ON FILE _____

CAN WE USE ADA FORM?_____

CAN WE DO PERIO SCALING (D4341) _____

HOW MANY QUADRANTS _____HOW OFTEN?_____

DOES INSURANCE COVER ARESTIN (D4381) _____

ARE SEALANTS COVERED _____

UNTIL WHAT AGE?_____

FOR WHICH TEETH?_____

IS THE PATIENT ELIGIBLE FOR FMS?_____

SPOKEN TO _____

INSURANCE MAILING ADDRESS (FOR DENTAL)

_____

_____

_____