INSURANCE INFORMATION

Subscriber's Name____

Subscriber's Birth Date____________________________________

Subscriber's Social Security # _______________________________

Subscriber ID #____

Group Number____

Insurance Carrier Name_____________________________________

Insurance Carrier Address___________________________________

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Insurance Carrier Phone #___________________________________

Payor ID #____

What type of coverage: Preventive and/or Restorative

Date insurance runs (what month to what month)___________________

How much coverage per year__________________________________

Deductible per year______________________________________

Patient's Name____

Patient's Birth Date______________________________________

Preventive % coverage (cleanings/x-rays)_________________________

Basic Restorative % coverage (fillings)___________________________

Major Restorative % coverage (crowns/bridges)_____________________

Endodontic % coverage (root canals)____________________________

Prosthetic % coverage (dentures/partials)_________________________

Oral Surgery % coverage (extractions/surgical)______________________

Periodontal % coverage (full mouth scaling)________________________