

***Individual Insurance Information**

Patient Name: _____ D.O.B.: _____
Insurance Company: _____ Phone #: _____
Employer: _____ Phone#: _____
Group #: _____ ID #: _____

What am I allowed to spend each year (annual maximum)? _____

Is my annual maximum based on a calendar year (Jan-Dec)? YES NO OTHER

If other, when does my benefit year begin and end? _____

Does my plan follow the current dental fee guide? YES NO

If no, which dental fee guide does my plan follow? _____

Procedures and Codes

At what percentage (%) is my basic restorative covered? _____

At what percentage (%) is major restorative (crown, bridges, dentures) covered? _____

At what percentage (%) is my periodontal (root planning/scaling) treatment covered? _____

How many units of root planning/scaling am I covered for each calendar year?
(code: 11111) _____

What is my coverage for endodontic (root canal) treatment? (code: 33131) _____

Is there a separate maximum for major restorative? YES NO

If yes, what is the maximum? _____

How often does my plan cover the following (Please indicate is not covered):

Recall Exam (code: 01202) _____ Fluoride (code: 12101) _____

Bitewing x-rays (code: 02142) _____ Sealants (code: 13401) _____

*** Confirmation of insurance coverage is the responsibility of the patient**

Extra Notes: