PRIMARY DENTAL INSURANCE

Policy Holder's Name ____

Patient's Name ____

Policy Holder's Date of Birth ________________ Male / Female Policy Holder's SSN ________________

Policy Holder's Employer ______________________________ Group/Policy # ________________

Name of Insurance Company ____

Mailing Address for Claims ____

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Insurance Company's Phone # ____

OFFICE USE ONLY

Type of Insurance	Standard	PPO	DMO	Flat Fee
Coverage	Single	Family	Employee/Spouse	Employee/Children

Payer #________________ Effective Date of Coverage ________________ Renews ________________

Individual Deductible $ ____________ Family Deductible $________________ Yrly Max $________________

Preventive/A ________________% Basic/B ________________% Major/C ________________%

_____ Waiting Periods ________/________ FMX/Pano ________________ Deductible Met

_____ Missing Teeth Clauses Sealants _____% up to age ________ ________________

_____ Replacement of Existing Add'l Info ________________ Used Benefits

- Crowns & Bridges ____________
- Dentures & Partials ____________

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Insurance I authorize release of any information concerning my (or my child's) health care, advise and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist or dental group otherwise payable to me. I am aware that no insurance company attempts to cover all dental costs and the agreement of the insurance company to pay for dental care is a contract between me and the company. I understand that this office will file my insurance for me, and that my insurance benefits can only be estimated. If my insurance company does not respond to the submitted claim within 60 days, I understand that I become responsible for the balance in full (all estimated insurance payments as well as my estimated amount due).

Signature of Responsible Party ______________________________ Date ________________

INSURANCE COVERAGE