

**Insurance Coverage**

PRIMARY DENTAL INSURANCE Yes No

Name of Insured/Subscriber DOB:

Insurance Company:

Grp.# Cert.# DIV#

SECONDARY DENTAL INSURANCE Yes No

Name of Insured/Subscriber DOB:

Insurance Company:

Grp.# Cert.# DIV#

**PRIMARY PLAN COVERAGE**

Deductible YES NO $\_\_\_\_\_\_\_\_

Assignment YES NO

EDI YES NO

Plan Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fee Guide: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specialist YES NO

Composites YES NO

Implants YES NO

Ortho YES NO Age \_\_\_\_\_\_\_\_\_\_

Max \_\_\_\_\_\_\_\_\_

%\_\_\_\_\_\_\_\_\_\_\_\_

Scaling Units \_\_\_\_\_\_\_\_\_\_\_ per \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Basic % \_\_\_\_\_\_\_\_\_\_\_ Max $ \_\_\_\_\_\_\_\_\_\_\_\_

Major % \_\_\_\_\_\_\_\_\_\_\_ Max $ \_\_\_\_\_\_\_\_\_\_\_\_

NPE: \_\_\_\_\_\_\_\_\_\_\_\_ Every \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PAN/FMX: \_\_\_\_\_\_\_\_ Every \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recall: \_\_\_\_\_\_\_\_\_\_\_ Every \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Polish: \_\_\_\_\_\_\_\_\_\_\_ Every \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BW: \_\_\_\_\_\_\_\_\_\_\_\_\_ Every \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Flouride: \_\_\_\_\_\_\_\_\_ Every \_\_\_\_\_\_\_\_\_until age \_\_\_\_\_