Patients Name: _____ SS# or ID# _____ DOB_____

Subscriber Name:_____ ID#_____ DOB_____

TEL #_____ Other #_____ Email_____

BREAK DOWN OF BENEFITS

Date_____

Insurance Name_____ Tel_____ Name Of Rep_____

Group #:_____

Effective Date: _____/_____/_____ **Type Of Coverage:** Fam:□ Single:□ Dependent:□

Yearly coverage □ Calendar year □ Other_____

Deductible: Fam: $_____ Single: $_____ Deductible paid **Y N** Waved On Preventative Yes □ No □

Annual Max: $_____ Amount Used: $_____

Preventative: _____% Basic: _____% Mayor: _____%

Perio: Mayor □ Basic: □ other_____ **Endo:** Mayor: □ Basic: □ other_____

Veneers at_____% Inlays at_____%

Implants at_____% Implant Crowns_____% Bonegraft at_____% Major surgery at_____%

Fillings on Molars paid as: Comp □ Amalgams □

Ortho: $_____ at _____% Age Limit_____ deductible waved Yes □ No □

Plan Type: Fee Schedule (Ins Prices): □ Reasonable & customary (Our Prices): □

Missing Tooth Clause: **Yes □ No □** Preauthorization **Yes□ No □ at $_____**

Waiting period on _____

Child Cover until Age _____

Exam & Prophy: 6 Months □ 2 In Calendar Year □ **Bwts __ every_____ FMX: 1 every_____ Last Taken: _____**

Perio Maintenance_____ per year or every_____ months combine with prophy Yes □ No □

Payment Sent To Patient □ Office □

Mail Claims To _____ City_____ State_____ Zip_____

NOTES:_____

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