Date: _____ Staff: _____ Rep Name: _____ Ref #: _____

INSURANCE INFORMATION

Insurance Name: _____ Insurance Ph #: _____ Payor ID: _____

Claims Address: P.O. Box _____

POLICY HOLDER INFORMATION

Patient Name: (Self) _____ Patient DOB: _____

Subscriber Name: _____ DOB: _____ ZIP: _____ SSN: _____

Group Name: _____ Group # _____

BENEFIT DETAILS

Effective Date: _____ ☐ ACTIVE ☐ INACTIVE

Max. Used $: _____ Max. Remaining : _____ Ded Met $: _____

WP: ☐ Yes ☐ No _____

MTC: ☐ Yes ☐ No _____

TX Dr. _____

Fee Sched: ☐ PPO ☐ DNOA ☐ UHC ☐ UCC ☐ Premier ☐ UCR(Office) ☐ Unicare(Grid+) ☐ Connection ☐ Metlife
☐ Dentemax ☐ Ameritas ☐ Cigna ☐ Guardian ☐ Humana ☐ DHA

PATIENT HX

EXAM: _____

☐ FMX ☐ PANO: _____

☐ SRP ☐ PERIO ☐ PROPHY : _____

☐ SEALANTS ☐ FILLINGS : _____

_____

_____

CROWNS | BRIDGES: _____

_____

_____

ORTHO

Adult Age: ☐ N/C ☐ NAL _____ Dep. Age: _____ ☐ Under ☐ Thru Age: _____ ☐ N/C ☐ NAL _____ %

LT Max $: _____ Used $: ☐ NONE _____ Remaining $: _____ Ded $: ☐ NONE _____

Met $: ☐ NO _____ Payments: (☐ Auto ☐ Manual) ☐ Monthly ☐ Quarterly ☐ Annually ☐ Lumpsum

Initial Payment: (Max | Fee) ☐ 0% ☐ 20% ☐ 25% ☐ 30% ☐ 33% ☐ 50% ☐ 100%

Additional Info: _____

Tx Hx? ☐ Yes ☐ No _____

(pt has braces & has new ins / moved here) Cover Work in Progress? Cover Work in Progress? ☐ Yes ☐ No