Primary Insurance Information – **DENTAL ONLY**

Insurance Company: ☐ Aetna ☐ Ameritas ☐ Blue Cross Blue Shield ☐ Cigna

☐ Delta ☐ Delta (Retiree) ☐ Guardian ☐ MetLife ☐ United Concordia

☐ United Healthcare ☐ Other: _____

Policy Holder's Information

First Name: _____ Last Name: _____ MI: _____

Social Security: _____ - _____ - _____ Date of Birth: _____/_____/_____

Phone Number: (_____) _____ - _____ Relation to Policy Holder: Self Spouse Child Other

Policy Type: ☐ Group ☐ Self **Member #:** _____

Group ID #: _____

GROUP INSURANCE (Through Employer): **Employment Status:** ☐ Full Time ☐ Retired

Employer: _____ Work Number: (_____) _____ - _____ Ext: _____

Policy Coverage

Note: In order for our office to provide an accurate quote for services **YOU WILL NEED** to contact your Insurance Provider to obtain the following information. Please keep in mind, this information reflects the discounts you may receive and/or will dictate the price you will be charged. ***Price quotes are always ESTIMATED based off your particular selected Insurance Policy. ***

Benefits:

Annual Maximum: $_____

Amount Remaining: $_____

Deductible: $_____ ☐ Deductible Met

Roll Over Coverage: $ _____

Policy Coverage Range: Calendar Year

Other: _____ (Month) to _____ (Month)

Insurance Contact Information:

1 (_____) _____ - _____

Address to Submit Dental Claims:

_____

_____

Confirmation # of call to verify benefits:

Procedure Coverage:

Basic Services: _____%

Major Services: _____%

Does your policy have the following stipulations?

Waiting Period? (Circle/Explain) Yes No

If so, how long? _____

Missing Tooth Claus? (Circle) Yes No

Are **Implants** covered? (Circle) Yes No

Orthodontic age limitations? _____

Maximum: $_____ Coverage %: _____

Payment period: _____

Are the following procedures considered **Basic** or **Major** services?

Sealants [D1351]: _____

Endodontic [D3310]: _____

Simple Extractions [D7140]: _____

Surgical Extractions [D7210]: _____

Bone Graft [D07953]: _____