Date_____

PRIMARY DENTAL INSURANCE ONLY

(Please note we are not a participating or contracted provider with any insurance plan)

Name of Patient_____ Birthdate:_____

Insured's Name:_____ Birthdate:_____

Insured's SS#:_____ Employer:_____

Insurance Company Name:_____ Group/Policy #:_____

Claims Address:_____ Phone:_____

City:_____ State:_____ Zip:_____

**************************FOR OFFICE USE ONLY BELOW**************************

Individual Yr. Max $_____ Benefit Period:_____

Individual Deductible $_____ Family Deductible $_____

Effective Date:_____ Waiting Period:_____

PREVENTIVE:_____ **PERIO:**_____

Initial Oral Exam: Interval_____ Perio Pro (4910): Interval_____

Periodic Oral Ex: Interval_____ SRP_____ Frequency_____

Prophy: Interval_____ **MAJOR**_____

Fluoride: Interval_____ Prosthodontics/Crowns, Bridges, Partials

PAN: Interval_____ & Dentures_____

BWS: Interval_____ Replacement Interval_____

Sealants: Age limit?_____ Frequency?_____ Missing Tooth Clause? _____Y _____N

Space Maintainers_____ OCC Guards? _____Y _____N

BASIC_____ Implants?_____Y_____N

ENDODONTICS_____

ORAL SURGERY_____

ORTHODONTICS:_____ Ortho Max $_____Age limit?_____