(Please circle)
Ins Info Already on File OR needed A.S.A.P.
Spoke to ________________________

Insurance Breakdown

Date:______________________ Name of Insurance Company:____________________________

Name of Insured Member:____

Group Number: ___________________________ I.D.# _____________________

1. What Fee Guide: Current or Other ______________________

2. Assignment allowed? Yes or No

3. Is your plan on a Calendar Year: Yes or No
   Other: ________to________

4. Is there a deductible. If Yes, Single:_________________ or Family:_____________

5. Basic treatment is covered at: _________% with a maximum of $_______________

6. Does it include endo and perio? Yes or No

7. Major treatment is covered at _________% with a maximum of $______________

8. Are the basic and major maximum: Combined or Separate

9. Is there any coverage for Orthodontics: Yes or No

   If yes, covered at __________% with a maximum of $_____________

   With an Age limit of: ____________yrs

10. Please indicate 6, 9, 12, 24 or 36 month interval for each of the following:

    Recall Exam: __________months Complete Exam: __________months
    Full Set of X-rays: __________months Panoramic X-ray: _________months
    Bitewings X-rays: __________months Polishing: ___________months
    Fluoride: __________months *and* Age limit? _________yrs

    Oral Hygiene Instruction: Yes or No Any limitations? ________________

11. Number of scaling units allowed each benefit year ________units Calendar Year or Rolling Months

12. Are Composite (white) Fillings allowed on molars? (23321) Yes or No
13. Are Pit and Fissure Sealants covered? (13401) Yes or No
14. Is there any coverage for Implants? (79931) Yes or No

15. Mailing address for all claims ____