Patient Information Form

How did you hear about our office?

☐ Current Patient ☐ Insurance ☐ Internet/Website ☐ Mailing ☐ Family/Friend

☐ Event ☐ Social Media ☐ Dental Office ☐ Other _____

Name _____ _____ _____ Gender _____

Last First MI

Title: ☐ Dr. ☐ Mr. ☐ Mrs. ☐ Ms. How do you wish to be addressed:_____

Address:_____

Mailing Address City State Zip

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____

Date of Birth: _____ Social Security #: _____ Employer: _____

Responsibilty Party Name: _____ Phone: _____

Emergency Contact Name: _____ Phone: _____

DENTAL INSURANCE INFORMATION

Primary Insurance Company Name: _____

Employee/Subscriber Name:_____

Last First MI

Relationship to Suscriber: ☐ Self ☐ Spouse ☐ Dependent DOB: _____ Subscriber ID #: _____

Group/Employer Name:_____ Group Number: _____

Secondary Insurance Company Name: _____

Employee/Subscriber Name:_____

Last First MI

Relationship to Suscriber: ☐ Self ☐ Spouse ☐ Dependent DOB: _____ Subscriber ID #: _____

Group/Employer Name:_____ Group Number: _____

Thank you for choosing our practice. We appreciate your confidence in our care and services.

Insurance Verification Form

INTERNAL USE ONLY

Patient Name: _____ DOB: _____

Subscriber Name: _____ DOB: _____Suscriber ID: _____

Insurance Company: _____ Rep Name: _____ Date: _____

Mailing Address: _____ Phone: _____ Fax: _____

Payor ID: _____ Group #: _____

Plan Type: ☐ PPO ☐ Traditional ☐ Capitation ☐ Fee schedule ☐ Out of Network Benefits: ☐ Yes ☐ No

☐ Fee Schedule Network Utilized: _____

COB: ☐ Standard ☐ Non-dup ☐ Birthday Rule

Pre-Authorization Required: ☐ Yes ☐ No Waiting Period ☐ Yes ☐ No Length _____ Basic/Major or Both

Maximum benefit: $ ☐ Calendar Year ☐ Plan Year (renewal date _____)

Remaining benefit: $ _____ Deductible: $ _____ Family Deductible: $_____

Does deductible apply to D & P? ☐ Yes ☐ No

Preventative _____% Basic _____% Major _____% Endo _____% Perio _____% Radiographs _____%

Occlusal Guards _____% Freq 1 x _____months SRP Frequency 1 x _____months How many quads of SRP per visit: _____

Sealants _____% Age Limitation _____ Freq 1 x _____ months/yrs/lifetime

Flouride _____% Age Limitation _____ Freq _____ Is there a missing tooth clause (MTC)? ☐ Yes ☐ No

Prophylaxis Freq: ☐ 2 x cal yr ☐ 2 x plan yr ☐ 1 x 6 months ☐ 1 x 12 consecutive months Age limitation: _____

Perio Maintenance Freq: ☐ 2 x cal yr ☐ 2 x plan yr ☐ 1 x 6 months ☐ 1 x 12 consecutive months

Radiograph: BWX_____ FMX/Pano_____ Periapicals_____

Posterior fillings downgrade? ☐ Yes ☐ No Molars / Pre-molars

Replacement Clause: Crowns _____ months/yrs Crown Downgrade? ☐ Yes ☐ No Dentures/Partials_____ months/yrs

Paid on Prep or Delivery? _____

Implants _____% Freq _____ if no impant coverage, are implant resorations covered? ☐ Yes ☐ No

6057 _____ 6058 _____

Ortho Coverage _____ Age Limit _____ Max _____

Verified By: _____ **Date:** _____