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:** ________________________