PATIENT'S INSURANCE INFORMATION

Today's Date: _____ Appt. at: _____

Patient's Name: _____ Home Phone: _____

SS #: _____ Work Phone: _____

D.O.B: _____

Responsible Party: _____ Rel. w/ Pt.: _____

SS #: _____

D.O.B: _____

Insurance Company's Name: _____

Ins.'s Tel Number: _____

Mailing Address for Claim: _____

Group #: _____ Group Name: _____

Effective Date: _____ Ending Date: _____

Yearly Max: $ _____ Used: $ _____ Remaining:$ _____

Deductible: _____ Has been met ☐ Yes ☐ No

Preventative: _____% Basic: _____%Major: _____%

Oral Surgery: ☐Tooth Extraction ☐Apicoectomy ☐ Removal of Cyst ☐Frenectomy

☐ Basic _____% ☐ Major_____%

☐Submit the claim to MEDICAL INS.

☐ Need FULL TIME STUDENT Evidence

☐ GA _____% with _____Impacted teeth or _____ not Impacted

Hx on FMX or PAN: _____ Frequency: 1 /___ years ☐ Eligible ☐ No

Remarks: _____

_____

Associate's Name: _____