INSURANCE INFORMATION TODAY'S date

PATIENT NAME_____________________________BIRTH DATE______________________

SOCIAL SEC.#_________________________RELATIONSHIP TO INSURED____________

INSURED'S NAME____________________________BIRTH DATE______________________

SOCIAL SEC.#___________________________EMPLOYER___________________________
EMPLOYER ADDRESS____
____

INSURANCE CARRIER____
MAILING ADDRESS____
____
PHONE#_____________________________FAX____________________________________

DO NOT WRITE BELOW THIS LINE
FOR OFFICE USE ONLY
****

CIRCLE ONE: PRIMARY / SECONDARY PAPER / ELECTRONIC

EFFECTIVE DATE____________________ ANNUAL DEDUCTIBLE __________

PREVENTIVE _________%
LIMITS:____

BASIC ______% LIMITS:____

MAJOR ______% LIMITS:____

X-RAYS ______% LIMITS:____

SEALANTS ______ LIMITS:____

FLUORIDE ______ LIMITS:____

EM VISIT ______% LIMITS:____

N2O ______ % IMPLANTS ___________ MTC? ________________

SPECIAL LIMITATIONS OR EXCEPTIONS FOR THIS POLICY:
____

ANNUAL MAXIMUM FOR BENEFITS:_________________________