Insurance Information

Subscribers Name: _____ DOB: _____ SSN: _____

Subscribers ID: _____ Subscriber's employer: _____

Your relationship to subscriber: _____

Patients Name: _____ **DOB**: _____ **SSN** :_____

Family Coverage: _____

Insurance CO: _____ **Phone number**: _____

Address: _____

Group#: _____

(*HFD staff will fill out the info below once we verify insurance)***.**

Effective date: _____ **Payor ID**: _____ **Calendar year**: Y / N
Waiting period: Y /N -_____ **Missing tooth clause**: Y or N

Max allowance: $_____ **Deductible**: $_____ **Family Deductible**: $_____

%Coverage:

Preventive: _____% **Basic**:_____% **Major**:_____% **Implants**: _____%

Special Notes: _____

Frequencies:

Exams: _____**BW's**: _____ **Pa's**: _____

Fmx/Pano: _____ **Last taken**: _____ **Prophy**: _____

Sealants: _____ **Fluoride**: _____

Crown and dentures pays on seat or impression date?

Copy of card: