Summeridge Dental Care

Insurance Coverage Form

Please call your insurance company to receive the details of your insurance plan. Please have the following information ready when you call the insurance company. You may copy the information from the insurance company directly onto this form and bring it into the office at your first visit.

Insurance company:_____
Policy Number:_____
Group number:_____

Yearly maximum benefit paid per person-Basic-$_____Major-$_____
Amount already used this benefit year?_____
Policy anniversary date-calendar yr. or anniversary date-month_____
Deductible to be paid-individual/family_____
Percentage coverage-Basic-_____
Percentage coverage-Major-_____
Current year fee guide? Y or N if not, which year? _____
New patient exam (code 01103) frequency-_____last time billed-_____
Recall frequency (code 01202)- 6 month or 9 month
Scaling units allowed- _____
White fillings permitted on molar teeth?_____
Specialist Coverage? Y or N
Nitrous oxide sedation coverage? Y or N

Thank you for taking the time to learn about your insurance coverage.