Your Information *(required by Insurance company)*

Patient's Name: Subscriber's Name:

Subscribers Date of Birth: Insurance Company Name:

Policy # Certificate #

Answers your Insurance Company must give you

GENERAL INFORMATION

Annual Maximum per patient: $ _____ Annual Maximum used to date: $ _____

Basic Maximum:$_____ Major Maximum $_____

Anniversary date of policy:_____Policy is "Calendar Year" or "Benefit Year"?

(month: _____ to _____)

Annual deductible per person?

Are benefits current with Ontario Dental Association fee guide? If not, what year?

DENTAL HYGIENE COVERAGE (measured in # of units, 1 unit = 15 minutes)

Scaling units covered per year: _____
Scaling units per "Rolling 12 months": ____
Scaling units per "Benefit Year": _____

How frequently "Recall Appointments"____ covered?
(eg. every 6 months)

COMMON PROCEDURES CODES *are these covered? Yes or No*

23321 White Fillings on Molars:

49211 Periodontal Irrigation:

12101 Fluoride:

13211 Oral Hygiene Instruction:

49101 Periodontal Re-evaluation:

42831 Emergency Periodontal Treatment:

PERCENTAGE COVERAGE:

Diagnostic_____%
Preventive _____%
Restorative _____%
Endodontic_____ %

Periodontal _____%
Basic _____%
Major _____ %