INSURANCE OVERVIEW

DR. KEVIN RUSSELO + ASSOCIATES

PATIENT NAME _____

POLICY HOLDER NAME _____

POLICY HOLDER DOB _____

POLICY HOLDER PHONE # _____

INSURANCE COMPANY _____

GROUP/POLICY # _____

CERTIFICATE # _____

Please contact your insurance provider and ask for a "Dental Breakdown"

COVERAGE

BENEFIT YEAR ◯ JAN-DEC ◯ OTHER _____ - _____

YEARLY DEDUCTIBLE ◯ NO ◯ YES $_____ **FEE GUIDE** CURRENT OTHER: _____

COMBINED MAX ◯ NO ◯ YES TOTAL $_____

SPECIALIST COVERAGE ◯ NO ◯ YES (I.E. Endodontist, Periodontist, Oral Surgeon fee guides)

BASIC COVERAGE _____% $_____ (I.E. cleanings, exams, filling, night guards, extractions)

MAJOR COVERAGE _____% $_____ (I.E. crowns, bridges etc)

ORTHO COVERAGE _____% $_____ Lifetime Maximum

FREQUENCIES

SCALING/PERIO	_____UNITS	/BENEFIT YEAR ◯	**OR**	____UNITS	/12 ROLLING MONTHS ◯
POLISHING	_____UNITS	/BENEFIT YEAR ◯	**OR**	____UNITS	/12 ROLLING MONTHS ◯
FLUORIDE	1	/BENEFIT YEAR ◯	**OR**	1	/____ ROLLING MONTHS ◯
RECALL EXAM	1	/BENEFIT YEAR ◯	**OR**	1	/____ ROLLING MONTHS ◯
BITEWINGS	1	/BENEFIT YEAR ◯	**OR**	____	/____ ROLLING MONTHS ◯
COMPLETE EXAM	1	/____ ROLLING MONTHS ◯	**PAN**	1	/____ ROLLING MONTHS ◯

***Please inform the dental office of any changes with your isurance ***