DR. KEVIN RUSSELO
+ ASSOCIATES

INSURANCE OVERVIEW

PATIENT NAME _____

POLICY HOLDER NAME _____

POLICY HOLDER DOB _____

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: _____

BASIC _____% $_____ (cleanings, exams, restos, night guards, extractions)

MAJOR _____% $_____ (crowns, bridges etc)

ORTHO _____% $_____ Lifetime Max

COMBINED MAX ◯NO ◯YES TOTAL $_____

SPEC COVERAGE ◯NO ◯YES

FREQUENCIES

SCALING/PERIO	_____/	BENEFIT YEAR ◯	**OR**	_____/ 12	ROLLING MONTHS ◯
FLUORIDE	1/	BENEFIT YEAR ◯	**OR**	1/_____	ROLLING MONTHS ◯
RECALL EXAM	1/	BENEFIT YEAR ◯	**OR**	1/_____	ROLLING MONTHS ◯
BITEWING X-RAYS	1/	BENEFIT YEAR ◯	**OR**	____/_____	ROLLING MONTHS ◯
COMPLETE EXAM	1/____	ROLLING MONTHS	**PAN OR FMS**	1/____	ROLLING MONTHS