DR. SAL ALCAIRE
+ ASSOCIATES

INSURANCE OVERVIEW

PATIENT NAME _____

POLICY HOLDER NAME _____

POLICY HOLDER DOB ____/____/____ **POLICYHOLDER 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 (Endodontist, Periodontist, Oral Surgeon)

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

MAJOR COVERAGE _____% $_____ (crowns, bridges)

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 to your isurance ***