Davis Dental Care

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105 Davis Drv. Newmarket, ON L3Y2M9

Insurance Coverage Information

Insurance Company Name: _____

Policy #: _____

I.D./Certificate #: _____

Employer's Name: _____

Insurance member's Name: _____

Patient's Name: _____

Questions to ask your insurance company for the breakdown

What year is the fee guide? _____
Is my coverage based on a calendar year? _____, If no, what year does it start and end? _____
Is there a deductible? (No/yes) If yes, how much is the deductible? $_____
What is the yearly maximum amount? $ _____; Is it combined? (yes/no)
If yes, major maximum amount: $ _____/year
Basic coverage: _____% ; Major coverage: _____%
Recall: (5 / 6 / 9 / 12months)
Units of scaling: _____ (year/rolling months)
Age restriction for fluoride? (yes/no) if yes, what age limit? _____
White fillings on molars? (yes/no)
Complete exam: 1x/____years
Panoramic x-ray: 1x/ ____years
EDI and assignment allowed? (yes/no)

Please bring this form back to our office and we will be more than happy to review your plan, limitations and help answer any questions you may have in regards to your insurance and the treatment we have recommended for you and your family.

I understand that it is my responsibility to inform the Davis Dental Care of any changes to my insurance plan, and any fee's that are not reimbursed by my plan are 100% my responsibility.

Signature of Patient:_____ Date: _____