

II. Dental Insurance Coverage Information

This Dental Insurance Coverage is for:

Date of Birth:

A1. Primary Dental Insurance Coverage:

Primary Insurance Coverage - If taking a copy of an insurance coverage card is not possible, please complete the following:

Subscriber/Insured's Name: _____ Insured's Birthdate: _____

Insured's SS/ID Number: _____ Group/ID Number: _____

Patient is the Subscriber/Insured's: self spouse/partner child other: _____

Name of Insurance Company: _____

Insurance Company Address: _____

Insurance Company Phone Number(s): _____

Assignment of Benefits: "For dental services rendered, I authorize that my dental insurance company receive claims and issue payment to Belltown Dental/Christine Shigaki D.D.S., P.L.L.C."

Signature of Subscriber/Insured: _____

A2. For Office Use (to be completed by Belltown Dental):

Ins. Effective Date: _____ Benefit Yr/ Calendar Yr: _____ Family/Members covered by this plan: _____

Coverage:	Type I:	%	Annual Max;:	Deductible:/	Family;:	Ded. on: I II III
	Type II:	%				
	Type III:	%	If incentive plan, level is	% on (date)	w/ a max possible of	%.
00150: Initial Comp. Oral Eval.			5M - 6M - 2x/Yr - 1x/Yr		Any Eval, limited to 2x/Yr.	
02100: Intraoral – complete series			3Yr - 5Yr - no frequency			
00470: Study Models: Yes/No			Type: I II III			
00120/01220: Exam – adult/child			5M - 6M - 2x/Yr - 1x/Yr			
00277: 7-8 Vertical Bitewing Films			6M - 1Yr - no frequency			
00274: Four (4) Bitewings			6M - 1Yr - no frequency			
01110/01120: Prophy – adult/child			5M - 6M - 2x/Yr			
01204/01203: Fluoride – adult/child			Adult: Y/N – Age Limit:			
01351: Sealants			Adult Y/N; Child Y/N; Age Limit:			
00180: Periodontal Evaluation			1x/Yr - 1x/2Yrs. - 1x/3Yrs			
04910: Periodontal Maintenance			2x/Yr - Type III: 3x/Yr - 4x/Yr			
04341: Quad Perio Scaling; 4+ teeth			1x/Yr - 1x/2Yrs. - 1x/3Yrs			
04342: Quad Perio Scaling; 1-3 teeth			1x/Yr - 1x/2Yrs. - 1x/3Yrs			
04381: Atridox			Type: I II III; Limits:			
Endo			Type: I II III		Crowns: Type ____ @ ____%	
Oral Surgery			Type: I II III		Paid: prep date: ____; seat date ____	
Nightguard: Yes/No; Perio/Bruxism			Type: I II III		Onlays: Type ____ @ ____%	
Veneers: Yes/No			Type: I II III			
Implant Coverage: Yes/No			Max:			
Orthodontia Coverage: Yes/No			Age Limit: Max.:			

B1. Secondary Dental Insurance Coverage:

Secondary Insurance Coverage - If taking a copy of an insurance coverage card is not possible, please complete the following:

Subscriber/Insured's Name: _____ Insured's Birthdate: _____

Insured's SS/ID Number: _____ Group/ID Number: _____

Patient is the Subscriber/Insured's: self spouse/partner child other: _____

Name of Insurance Company: _____

Insurance Company Address: _____

Insurance Company Phone Number(s): _____

Assignment of Benefits: "For dental services rendered, I authorize that my dental insurance company receive claims and issue payment to Belltown Dental/Christine Shigaki D.D.S., P.L.L.C."

Signature of Subscriber/Insured: _____

B2. For Office Use (to be completed by Belltown Dental):

Ins. Effective Date: _____ Benefit Yr/ Calendar Yr: _____ Family/Members covered by this plan: _____

Coverage: Type I:	%	Annual Max;:	Deductible:/	Family;:	Ded. on: I II III
Type II:	%				
Type III:	%	If incentive plan, level is	% on (date)	w/ a max possible of	%.

00150: Initial Comp. Oral Eval.	5M - 6M - 2x/Yr - 1x/Yr	___Any Eval, limited to 2x/Yr.
02100: Intraoral – complete series	3Yr - 5Yr - no frequency	
00470: Study Models: Yes/No	Type: I II III	
00120/01220: Exam – adult/child	5M - 6M - 2x/Yr - 1x/Yr	
00277: 7-8 Vertical Bitewing Films	6M - 1Yr - no frequency	
00274: Four (4) Bitewings	6M - 1Yr - no frequency	
01110/01120: Prophy – adult/child	5M - 6M - 2x/Yr	
01204/01203: Fluoride – adult/child	Adult: Y/N – Age Limit:	
01351: Sealants	Adult Y/N; Child Y/N; Age Limit:	
00180: Periodontal Evaluation	1x/Yr - 1x/2Yrs. - 1x/3Yrs	
04910: Periodontal Maintenance	2x/Yr - Type III: 3x/Yr - 4x/Yr	
04341: Quad Perio Scaling; 4+ teeth	1x/Yr - 1x/2Yrs. - 1x/3Yrs	
04342: Quad Perio Scaling; 1-3 teeth	1x/Yr - 1x/2Yrs. - 1x/3Yrs	
04381: Atridox	Type: I II III; Limits:	
Endo	Type: I II III	Crowns: Type ___ @ ___%
Oral Surgery	Type: I II III	Paid: prep date: ___; seat date ___
Nightguard: Yes/No; Perio/Bruxism	Type: I II III	Onlays: Type ___ @ ___%
Veneers: Yes/No	Type: I II III	
Implant Coverage: Yes/No	Max:	
Orthodontia Coverage: Yes/No	Age Limit: Max.:	