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.:	