Insurance Plan Information

Photocopy/Scan Insurance Card Here

Insurance Company: _____ Group Number: _____

Subscriber Name: _____ Subscriber ID: _____

Subscriber Birthdate: _____

Benefit Year Ends: _____ Yearly $ Limit: _____

Basic Coverage: ☐ 0% ☐ 50% ☐ 80% ☐ 100%
☐ Other: _____

Major Coverage: ☐ 0% ☐ 50% ☐ 80% ☐ 100%
☐ Other: _____

How often are examinations (check-ups) covered? ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other: _____

How often are cleanings (scaling) covered? ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other: _____

How often is polishing covered? ☐ 6 months ☐ 9 months ☐ 12 months ☐ Other: _____

Insurance Plan Release of Information Authorization

I, _____, hereby authorize Dr. Matthew Jourdain and any of persons under his employment to contact the insurance company outlined above in order to discuss the dental benefits on my behalf. The agent of the insurance company is hereby instructed to release any and all information with regards to, but not limited to: outstanding insurance claims, preauthorization, claim payment, and benefit eligibility as it applies to the policy outlined above. This release applies not only to me, the undersigned, but all members of my family covered under this insurance plan. This authorization will be effective from the date signed, until such time as the policy terminates. This written release will supersede any privacy policy in place by the insurance company as it applies to my dental health benefits.

Subscriber Signature: _____ Date: _____

Witness Signature: _____ Date: _____