JAN E. ANGIER, D.D.S.

DENTAL INSURANCE INFORMATION SHEET

If you have insurance, please provide us with the information requested below:

Patient's Name:____

Insured's Name*(if different from patient):______________________________

Employee SS# and DOB:_______________________________________

Employer:____

Insurance Company Name, Address and Phone Number:

____

____

____

Group Number:____

Please call your insurance company and request the following information:

Name of person you are speaking with:_____________________________

Insurance Effective Date:_____________________________________

Yearly Plan Maximum:____________ Maximum Remaining:_______________

Yearly Deductible:_______________ Has it been met? _________________

Do periodontal procedures fall under Basic or Major? ___________________

At what percentage is Perio covered?______________________________

Pre-estimate required?____________ Implants covered?_________________

May I see any dentist I choose?___________________________________

*****Payment is due when services are rendered.*****

As a courtesy, we will file your insurance so you may be reimbursed. The doctor is practicing the highest standard of care recommended by the dental profession, which she believes best serves your needs. However, your insurance company may not accept the same standards and indications for a certain procedure and therefore deny payment. If you have any questions relating to this matter we request you discuss them with our staff prior to services being rendered.

Signature/Date:_______________________________________