ATTENTION:_____

Welcome to our practice!

In order to provide you with the service of billing your dental insurance plan directly, we would ask you to please provide us with your insurance information. Insurance companies no longer release details and information regarding your plan to the dental office as we are a separate, third party. It is ultimately your responsibility to be aware of the details of your own dental coverage.

Please return to our office this insurance questionnaire by fax to 403-258-3913, two days prior to your scheduled appointment. You can find the answers with the help of your Human Resources/plan administrator at work or by contacting your insurance carrier directly. Please note: The questionnaire must be COMPLETED in FULL, otherwise we cannot bill your plan directly without these important plan details.

Thank you for your cooperation. We look forward to seeing you.

Appointment Booked_____

Patient/Policy Holder Name_____

Insurance Company_____

Employer/Company Name_____

Group/Plan Number_____ Division # if applicable_____

I.D./Certificate/Employee Number_____

Plan Administrator of Ins. Co Contact_____

Name of Person Confirming Benefit Details

Basic Coverage %_____ Major Coverage %_____

Yearly Maximum Allowed $_____ Is Basic & Major Combined_____

Units of Scaling/Root Planing Allowed #_____

Frequency (circle one) 12 rolling months, or per calendar year, or per benefit year.

Recall Frequency Allowed # _____

Bite Wings & Polish Frequency Allowed # _____

Adult Fluoride Coverage/Frequency_____

Panorex frequency allowed_____

Is there a Deductible applicable_____

Is this Benefit Year a Calendar Year_____

Is assignment of benefits allowed_____

Is the reimbursement cheque mailed directly to the dental office _____

Please FAX completed form to 403-258-3913. Thank you.