wrd

white rock dental

Patient Name:	Date:

Insurance Company _____

Effective Date of Coverage _____

Group No. _____ ID/Cert No. _____

Name of Employer _____

Name of Policyholder _____

Date of Birth of Policyholder _____

A _____% Limit _____

B _____% Limit _____

C _____% Limit _____

Policy Year End _____

Fee Guide _____

Deductible _____

Recall Frequency _____

Scaling/Root Planning Limit _____

- ❑ Adult Fluoride
- ❑ Sealants Age Limit _____
- ❑ Posterior Composites
- ❑ EDI (Electronic Billing)