Kevin L. Caldwell DDS, PC

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Dental Benefits Insurance Form

Please contact your dental provider to fill this form out and return to our office **BEFORE** your dental appointment.

Date: _____

Patient Information:

IS DR. CALDWELL IN MY NETWORK: Y / N

Patient Name: _____ SSN (Patient): _____

Subscriber Name: _____ DOB (Patient): _____

Subscriber Employer's Name: _____ DOB (Subscriber): _____

Group/Plan Number: _____

ID Number: _____ Payor ID Number: _____

Insurance Claim Mailing Address:

_____

Insurance Dental Phone Number: _____

Insurance Effective Date: _____

Waiting Period: Y / N Year Type: Calendar / Plan

Individual Deductible: $_____ Family Deductible: $_____

Dental Maximum: $_____

Deductible Apply To: Preventative / Basic / Major

Dental Benefits:

Preventative _____ % Basic _____ % Major _____ %

LAST Bitewing X-Ray Date: _____ Orthodontic Maximum: $_____

Age Limit: Y / N

LAST FMX/Pano X-Ray Date: _____