INSURANCE QUESTIONNAIRE

NAME:_____D.O.B:_____

EMPLOYER:_____

INSURANCE CO:_____

POLICY #:_____PLAN ID:_____

ANNUAL MAXIMUM:_____

DO YOU HAVE A YEARLY DEDUCTIBLE (PER INDIVIDUAL OR FAMILY)?_____

PLAN ANNIVERSARY: IS IT JAN 1?_____OTHER DATE:_____

DO YOU HAVE MAJOR COVERAGE (CROWNS, BRIDGES, DENTURES)?_____

ARE YOU COVERED FOR THE CURRENT YEAR FEES OR OLDER FEES?_____

RECALL FREQUENCY (6, 9 OR 12 MONTHS):_____

HOW MANY UNITS OF SCALING DO YOU HAVE EACH YEAR?_____

DOES YOUR PLAN COVER TOOTH COLOURED FILLINGS?_____