SEMIAHMOO
Dental Centre

INSURANCE FORM

PLEASE PRINT

Patient's Name

Relationship to Patient (if different)

INSURANCE INFORMATION

DENTAL INSURANCE PRIMARY CARRIER

Insurance Company Policy # ID or Certificate #

Policy Holder Date of Birth (DD/MM/YY)

Plan Coverage Basic % Major % Ortho %

Yearly Deductible $ Yearly Limit (Basic) $ (Major) $ (Combined) $

Scaling & Root Planning Units per year Recall Frequency Months or 2 x Calendar

DENTAL INSURANCE SECONDARY CARRIER

Insurance Company Policy # ID or Certificate #

Policy Holder Date of Birth (DD/MM/YY)

Relationship to Patient

Plan Coverage Basic % Major % Ortho %

Yearly Deductible $ Yearly Limit (Basic) $ (Major) $ (Combined) $

Scaling & Root Planning Units per year Recall Frequency Months or 2 x Calendar

PLEASE PRINT AND COMPLETE THIS FORM AND BRING WITH YOU ON YOUR FIRST APPOINTMENT.