SUNRISE DENTAL, DINAH B. VICE, DDS PA
1801 E FRANKLIN ST CHAPEL HILL, NC 27514

POLICY HOLDER'S NAME: _____ PHONE #: _____

POLICY HOLDER'S SS#/ID#:_____ INSURED'SDOB: _____

EMPLOYER: _____ GROUP#:_____

INSURANCE COMPANY: _____ INS. CO. _____

PATIENTS COVERED: _____

Authorization and Release

I understand that the information I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my medical status. I authorize the dental staff to perform the necessary dental services for my diagnosis, treat and receive payments from my insurance company. The office may file the necessary form to receive full benefits of coverage. However, this office cannot guarantee any estimated coverage. ***My insurance coverage is an agreement between my insurance company and me. I am responsible for all charges and if the insurance company does not pay within 45 days I must pay in full. Should this become a collection issue, I assume all costs of collection including but not limited to court costs, interest and legal fees. It is the patient's responsibility to know his or her insurance benefits.***

Signature of Insured/Co-Insured: _____Date: _____

EFFECTIVE DATE: _____ Benefit Year: _____ Verified By: _____Date: _____

Deductible: $ _____ Met$ _____ Family$ _____ Yearly Max$ _____ Used$ _____

Diagnostic% _____ Limited Exam (0140) % _____Preventive% _____

Basic% _____(Y) (N) | Perio% _____ Quads _____ | Endo% _____ | Surg%_____ (7220^) _____

***Ask if they downgrade restorative**

C&B% _____(Y) (N) | Payable on (Prep) (Seat) | Build Up (2950) (Y) (N)

Night guard (9940) _____ Freq. _____

Implant% _____ (6010) (6056) (6059) | Bone Graft (7953) _____

Ortho% _____

Prophy [ ] 6 months [ ] Twice per: Calendar year/ Plan year

FMD (4355) % _____ Exam same day (Y) (N)

Perio Main (4910) % _____ Frequency _____ | Arestin (4381) _____

Fluoride% _____ [ ] 1xYear [ ] 2xYear Age _____ | Sealants% _____ Age _____

Radiographs

Bitewings (0274) every _____ Last date of service _____

FMX (0210) / PANO (0330) every _____ _ Last date of service _____

PA (0220/0230) _____ Frequency _____CT (0367) _____

Limitations

Waiting Period? (Y) (N) Basic _____ Major _____

Missing tooth clause _____

Replacement time: C&B _____ D&P _____