

SUNRISE DENTAL, DINAH VICE DDS PA II  
1009 SPRING FOREST RD. RALEIGH, NC 27615

POLICY HOLDER'S NAME: \_\_\_\_\_ PHONE #: \_\_\_\_\_  
POLICY HOLDER'S SS#/ID#: \_\_\_\_\_ INSURED'S DOB: \_\_\_\_\_  
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 \_\_\_\_\_