DR. KEVIN RUSSELO + ASSOCIATES

INSURANCE DETAILS

PATIENT NAME

POLICY HOLDER NAME

POLICY HOLDER DOB

INSURANCE COMPANY

GROUP/POLICY #

CERTIFICATE #

COVERAGE

BENEFIT YEAR: CALENDAR YEAR OR OTHER:_____

BASIC	%	$	PER BENEFIT YEAR
ENDO	%	$	PER BENEFIT YEAR
PERIO	%	$	PER BENEFIT YEAR
MAJOR	%	$	PER BENEFIT YEAR

FREQUENCIES

	X			
SCALING/PERIO		BENEFIT YEAR	OR	____ ROLLING MONTHS
FLUORIDE		BENEFIT YEAR	OR	____ ROLLING MONTHS
RECALL EXAM		BENEFIT YEAR	OR	____ ROLLING MONTHS
BITEWING X-RAYS		BENEFIT YEAR	OR	____ ROLLING MONTHS
COMPLETE EXAM		BENEFIT YEAR	OR	____ ROLLING MONTHS
PAN OR FMS X-RAYS		BENEFIT YEAR	OR	____ ROLLING MONTHS