DR. KEVIN RUSSELO
+ ASSOCIATES

INSURANCE OVERVIEW

PATIENT NAME _____

POLICY HOLDER NAME _____

POLICY HOLDER DOB _____

INSURANCE COMPANY _____

GROUP/POLICY # _____

CERTIFICATE # _____

Please contact your insurance provider and ask for a "Dental Breakdown"

COVERAGE

BENEFIT YEAR ☐ JAN-DEC OTHER _____

BASIC _____% $_____ (cleanings, exams, resto, extractions)

MAJOR _____% $_____ (crowns, bridges etc)

COMBINED MAXIMUM ◯ YES ◯ NO

FREQUENCIES

SCALING/PERIO	☐ BENEFIT YEAR	**OR**	/ 12 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