



LYNNE D. MARTZ, D.D.S.

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AESTHETIC NEUROMUSCULAR & FUNCTIONAL DENTISTRY

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DENTAL INSURANCE BENEFIT

We are pleased to assist you by accepting assignment of benefits for dental insurance where possible. For those who enjoy dental benefits, we ask you to pay your estimated portion for which you are responsible, at the time of treatment. It is a courtesy and privilege to partner with you to maximize your benefits. Once final payment has been received from your insurance company we will reconcile your account and send you a statement for any difference.

Please remember, your dental benefit plan is typically provided to you by your employer. It is a contract between you, your employer, and the dental insurance provider.

Name of Insured:	_____	Insured's Birth Date:	_____
Insured's Privacy ID #:	_____	Insured's Group No:	_____
Insurance Plan Name:	_____	Insurance Plan Phone:	_____
Insurance Plan Address:	_____		
	Street	City	State Zip
Insured's Employer:	_____		
Employer Address:	_____		
	Street	City	State Zip

Your insurance company may require the use of your social security number (rather than Privacy ID #) to be used as identification. All information that is obtained from you by this office is protected and kept confidential. Every reasonable measure to prevent unauthorized disclosure of your protected health information is practiced.

Important Dates

Date of last Professional Cleaning	_____
Date of last Bitewing Digital Images*	_____
Date of last Full Mouth Digital Images*	_____

* Please contact your previous dentist to authorize release of all digital images or x-rays and request that a copy be forwarded to our office prior to your first visit.



Benefits Provided

We request that you contact your employer’s Human Resources department or insurance company directly to determine your plan’s allowances and itemize them below.

Deductible _____ **Yearly Maximum** _____
Eligibility Date _____ **Calendar Period** _____
Is there a Waiting Period for any benefits? _____

Your insurance company will pay what percentage for the following services?

Diagnostic – Examination, Digital Images _____ %
Preventative – Professional Cleaning, Sealants _____ %
Basic – Restorative Resin Only Filling _____ %
Major – Crowns _____ %
Endodontics – Root Canal Therapy _____ %
Periodontics – Gum Therapy _____ %
Periodontal Maintenance – 4910 _____ %
Oral Surgery – Extractions, biopsy _____ %
Nightguard _____ %
Prosthodontics – Dentures, Bridges _____ %
Implant Coverage _____ %

Do they pay based on UCR (Usual and Customary Fee) or a Fee Schedule ?

Frequencies (How often does your insurance pay for these procedures)

Professional Cleaning _____
Examinations _____
Bitewings (Digital Images/X-rays) _____
Full Mouth/Pano (Digital Images/X-rays) _____
Periodontal Maintenance (Dental Code D4910) _____

I authorize payment of the dental insurance benefit directly to the office of Drs. Martz & Marshall. I also authorize release of any information, including the diagnosis and record of treatment or examination rendered, to my dental insurance benefit plan.

Patient Signature _____
Date

If the client is a minor, a parent or legal guardian must sign.

Parent of Legal Guardian _____ _____
Relationship to Patient _____ **Date**