Dentistry with a Smile, LLC
Dr. Suhair Shamoon
920 Plymouth Ave.
Fall River, MA 02721-1944
508-672-6471

YOUR INSURANCE COVERAGE

(FOR OFFICE USE ONLY)

PATIENT NAME: ____

COMPANY: _____________________ **PLAN:** _______________________ **EFFECTIVE DATE:** ___________

Your yearly maximum allowance is $___________.____ per member.

You have a $________.____ deductible for **Types**_____**&**_____. **Met:** _______ **Payor ID:** ________

Type I = ____% coverage. (e.g. exams, prophys & x-rays)

Type II = ____% coverage. (E.g. fillings, extractions, denture repairs, & relines.)

Type III =____% coverage. (e.g. crowns, root canals, & dentures.)

NETWORK: IN OUT GROUP:_________________ **Group#:**_________ **SBID#:**___________

Payment for services not covered by insurance must be made **ON THE DAY THE SERVICE IS RENDERED**. You can pay by cash, check, or credit card (MasterCard, Visa, Discover, and Care Credit Dental Card). If you are not prepared to do so, please make arrangements with the receptionist PRIOR to the appointment date.

SEALANTS: Under ______ on unrestored Permanent Molars

FLUORIDE: Under______ every ______ months

FMX: Once every ______ years Elig:_________ **FMD:** ______ ________________________

BW: Once every ______ months **PRO:** _______ **per year / Child Pro Age:** _______

HISTORY: ______ **PERIO MAINT:**_________ **every**_____________

MISSING TOOTH CLAUSE: ______ ____

IMPLANT COVERAGE: ______ **Composites:** ______________________________

Waiting Period: ______ ____

Exams: ______ **per year** ____

INSURANCE AUTHORIZATION FOR

SUHAIR A. SHAMOON, D.M.D

OF DENTISTRY WITH A SMILE, LLC.

SIGNATURE ON FILE

I authorize use of this form on all my insurance submissions.

I authorize release of information to all my insurance carrier(s).

I understand that I am responsible for my account.

I authorize my dentist to act as my agent in helping me obtain payment from my insurance carrier(s).

I authorize payment directly to my dentist.

I permit a copy of this authorization to be used in place of the original.

I understand that I am financially responsible for any treatment that is a non-covered service by my insurance carrier(s).

NAME: ____

(PLEASE PRINT)

NAME: ____ ____/____/____

(SIGNATURE) **(DATE)**

INSURANCE INFORMATION

Insured's Name: ____

Address: ____

Employer: ____

Date of Birth: ____

S.S. #: ____

Employer's Phone #: ____

Name of Dental Insurance: ____

Subscriber ID#: / Group #: ______________________ ______________________

I understand that payment of my co-insurance/deductible is due at time of service.