Additional Cleaning Request

Patient				
First Name		MI	Last Name	
Phone		Email		
Member ID				

Patient Legal Guardian (if applicable)				
First Name		MI	Last Name	
Phone		Email		
Member ID (*If applicable*)				

I, _____ a member of HRI Dental & Vision, understand that I qualify for an additional cleaning due to the following *(check one)*:

☐	Member with special needs (ex. Autism, cerebral palsy, Down syndrome, cognitive disabilities)	
☐	Member with diabetes	
☐	Member is pregnant.	Expected due date:

If pregnant, please have your health care provider fill out the following:

Health Care Provider			
Name and Practice			
Phone Number			
Provider Signature		Date	

By signing below the patient and/or guardian agrees that the above information is correct and that they qualify for the additional cleaning benefit. HRI Dental & Vision will keep this on file to verify the patient's dental coverage. This waiver shall not be shared or distributed under any circumstances.

Patient Name	Patient Signature	Date
Legal Guardian Name *(if applicable)*	Legal Guardian Signature *(if applicable)*	Date

Please submit this form via email to Enrollment@InsuringSmiles.com or via mail to:
PO Box 659, Evansville, IN 47704

HRI Dental & Vision
1449 Kimber Lane, Suite 103A
Evansville, Indiana 47715
800-727-1444
Insuringsmiles.com

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