Please complete the highlighted portion and bring it with you to your appointment along with your dental insurance verification card and/or insurance claim form.

Thank You!

DENTAL INSURANCE VERIFICATION FORM

TODAY'S DATE _____

PATIENT'S NAME _____

HOME PHONE _____ WORK PHONE _____ CELL PHONE _____

PATIENT'S SS #/SIN _____ D.O.B. OF PATIENT _____ E-MAIL _____

IF PATIENT IS 19 YRS. OR OLDER - FULL TIME STUDENT YES / NO

INSURED'S NAME _____ PATIENT'S RELATIONSHIP TO INSURED _____

INSURED'S SS #/SIN _____ D.O.B. OF INSURED _____

INSURED'S EMPLOYER _____ PHONE NO. _____

INSURANCE COMPANY _____ PHONE NO. _____

GROUP NO. _____ POLICY NO. _____ EMPLOYEE NO. _____

(OFFICE USE)

DATE INSURANCE VERIFIED _____ DATE EMPLOYMENT VERIFIED _____

EFFECTIVE DATE OF INSURANCE _____ DEPENDENT COVERAGE _____

DEDUCTIBLE $ _____ FAMILY DEDUCTIBLE $ _____

DEDUCTIBLE APPLY TO PREVENTIVE SERVICES YES / NO CARRY OVER YES / NO

ANNUAL MAXIMUM $ _____ BALANCE OF MAXIMUM AVAILABLE $ _____

BENEFIT YEAR - CALENDAR OR FISCAL

MAIL FORMS TO: _____

_____

_____

PREVENTIVE SERVICES _____% CLEANINGS PER YEAR _____

FLUORIDE: (AGE LIMITS & TIMES PER YEAR) _____

FULL MOUTH X-RAYS & BWX: (TIME LIMITS) _____

SEALANTS: YES / NO (LIMITS) _____

BASIC SERVICES _____% PERIODONTICS _____%

ENDODONTICS _____%

MAJOR SERVICES _____% ORAL SURGERY _____%

PRE-DETERMINATION MANDATORY	YES	NO
SIGNATURE ON FILE-ACCEPTED	YES	NO
INSURANCE REQUIRES ORIGINAL CLAIM FORM	YES	NO
DUAL INSURANCE - BIRTHDAY RULE APPLY	YES	NO
WAITING PERIOD ON MAJOR WORK	YES	NO
MISSING TOOTH CLAUSE	YES	NO
REPLACEMENT - 5 YEAR RULE APPLY	YES	NO
ORAL SURGERY - FILE ON MEDICAL	YES	NO

CONTACT NAME AT INSURANCE COMPANY _____ DIRECT EXTENSION: _____

VERIFIED BY _____

FIRST LAST MIDDLE INITIAL

DENTAL INSURANCE VERIFICATION FORM