DENTAL INSURANCE VERIFICATION FORM

Appointment time_________Today's Date________

Patients Name_____________________________referred by___________
Address____
Home#____________work#_______________cell#___________________
DOB_______________SS#___________________Student?______________

INSURED's

Name_____________________________DOB_________SS#______________

Employer Name__________________________#______________________

Insurance Company_______________________Group #_______________

Date Effective___________single/spouse/family

Deductibles (single)______(family)_____ apply to preventative Y/N

Annual Maximum__________Calendar or Fiscal Year_____________

Frequencies: exam/prophy-2yr or 1/6 months-FL___Yr___age

FMX-1/_____yr: BWX_____/yr , PTE Mandatory Y or N

Preventative_____%Basic______%Major______% wait period______

Ortho? Y/N age______ :Sealants Y/N age______, Limits________

Missing tooth clause-Y/N, 5 year replacement rule Y/N

Mail Claims to____
Contact Name___________________________ Date verified___________