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_____