INSURANCE VERIFICATION FORM

Date:_____
Patient Name:_____
Patient SS#:_____
Patient DOB:_____
Student Status:_____

Insured Name:_____
Relationship to Patient:_____
Insured SS#:_____
Insured ID# (if different than SS#):_____
Insured DOB:_____
Employer:_____
Group#:_____

Insurance Company Name:_____
Phone Number:_____
Claims Address:_____

Effective Date:_____
Maximum:_____Calendar year: Yes No
Deductible:_____Amount Met_____
Preventative:_____
Basic:_____Major:_____
Oral Surgery:_____Perio:_____
Implants:_____Endo:_____Ortho:_____

Frequency Limits:_____Missing tooth clause: Yes No
FMX:_____5 year clause: Yes No
Sealants:_____Any waiting periods: Yes No
Night Guard:

Other notes:

_____