Dental Insurance Verification Form

Patient/Subscriber Information

Patient Name		**Date of Birth: DD/MM/ YYYY**	
Insurance Company Name:		**Insurance claim address:**	
Insurance Phone:		**Insurance effective date:**	
Employer Name:		**Waiting period Y / N**	
Subscriber Information			
Subscriber Name: INSURED		**Date of Birth: DD/MM/ YYYY**	
Subscriber ID#		**Plan/Group#**	
Employee Name:		**Year Type: Calendar / Plan**	
OFFICE USE ONLY Individual Deductible: $		**OFFICE USE ONLY Met to date: $**	
Deductible applies to: Preventive / Major		**Dental Maximum: $**	
Class III: Major_____%			
Missing Tooth Clause: Y / N		**Implants Benefits: Y / N**	
Perio Coverage: Y / N		**Night Guards: Y / N**	
Oral Surgery Coverage: Y / N			