Dental Insurance Verification Form

PATIENT INFORMATION

First name: _____ Last name: _____

Date of birth: _____ dd / mm / yyyy Gender: _____

Address: _____ City: _____

State: _____ Zip code: _____

Home phone number: _____ Work phone number: _____

Social security number: _____

Diagnosis:

Applicable ICD-9-CM diagnosis code(s):

Anticipated CPT code(s) for procedure(s):

PATIENT INSURANCE INFORMATION

Primary insurance company: _____ Policy number: _____

Group number: _____ Primary insurance phone no.: _____

Subscriber's first name: _____ Subscriber's last name: _____

Date of birth: _____ dd / mm / yyyy Subscriber's relationship to patient: _____

Address: _____ City: _____

State: _____ Zip code: _____

Secondary insurance company: _____ Policy number: _____

Group number: _____ Secondary insurance phone no.: _____

Subscriber's first name: _____ Subscriber's last name: _____

Date of birth: _____ dd / mm / yyyy Subscriber's relationship to patient: _____

Address: _____ City: _____

State: _____ Zip code: _____

PREVENTATIVE COVERAGE

Covered %: _____

Is there a waiting period for preventative coverage?

◯ Yes ◯ No

Effective date: _____ dd / mm / yyyy

Prophylaxis/Exam frequency: _____

Bitewing frequency: _____

Last FMS: _____

Eligible for an FMS every years: _____

Eligible for an FMS now?

◯ Yes ◯ No

Fluoride varnish frequency: _____

Is there an age limit on fluoride varnish applications?

◯ Yes ◯ No

If yes, at age: _____

Is there sealant coverage?

◯ Yes ◯ No

Teeth covered:

☐ Molars

☐ Premolars

Is there an age limit on sealants?

◯ Yes ◯ No

If yes, at age: _____

Replace on sealants Is: _____