Insurance Verification Form

Please contact your insurance carrier by phone to gather the necessary information below. Complete and submit this form to our office at your first visit.

Patient Name:_____

Group # _____

Maximum per year_$_____Deductible_$_____

Service Type	Percentage
Preventative & Diagnostic	
Basic	
Major	
Orthodontics	
Fluoride	
Date of Last X-rays	

Please ask your insurance about any additional services you may be interested in.

Insurance Company Representative_____

Your insurance claim will be processed in accordance to the benefits reported to our office. This is not a guarantee of payment by your insurance carrier. If your claim is denied due to exclusions and or limitations, you are responsible for payment in full.

Patient signature_____Date_____