INSURANCE VERIFICATION FORM

Please provide our office with the following information so that we may properly verify your insurance coverage. If you do not have this information, you may run the risk of not having any dental benefits and the responsibility of your bill.

Please provide a copy of your dental card at your next appointment.
Healthcare cards often are mistaken for dental, so please double check your card carefully.

Patient Name: ______________________ **Birth Date:** ______________

Primary Dental Insurance

Insurance Company: ______________________
Subscriber's Name: ______________________
Suscriber SS # ______________________
Subscribers Date of Birth: ______________________
Subscribers Employer: ______________________
Insurance Phone # ______________________
Insurance Address: ______________________
Group # ______________ ID # ______________

Secondary Dental Insurance

Insurance Company: ______________________
Subscriber's Name: ______________________
Suscriber SS # ______________________
Subscribers Date of Birth: ______________________
Subscribers Employer: ______________________
Insurance Phone # ______________________
Insurance Address: ______________________
Group # ______________ ID # ______________