Dental Insurance Verification Form

Patient information			
Full name:	Date of birth:	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:	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:	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:	
Prophylaxis/exam frequency:	Bitewing frequency:		
Eligible for an FMS every years	Last FMS:		
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 at:			