

# Dental Insurance Verification Form

Patient Information				
First Name	Last 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				
<b>Primary</b> Insurance Company		Policy Number	Group Number	
<b>Primary</b> Insurance Phone No.	Subscriber's First Name	Subscriber's Last Name	Date of Birth	
Subscriber's Relationship to Patient				
Address		City	State	Zip Code
<b>Secondary</b> Insurance Company		Policy Number	Group Number	
<b>Secondary</b> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No    Effective Date:			
Prophylaxis/Exam Frequency	Bitewing Frequency	Eligible for an FMS every _____ years		
Last FMS	Eligible for an FMS now? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Fluoride Varnish Frequency				
Is there an age limit on fluoride varnish applications? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, at age:				
Is there sealant coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No    Teeth Covered <input type="checkbox"/> Molars <input type="checkbox"/> Premolars				
Is there an age limit on sealants? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, at age:				
Replace on sealants is:				