

Patient Number: \_\_\_\_\_  
 Procedure(s): \_\_\_\_\_

## Insurance Verification Form

Please fill out the top half only. Please print.

Today's Date: \_\_\_\_\_

No Charge Pano : Y / N

Patient's Name:	Address:
Patient's Date of Birth:	Apt#      City and Zip:
Patient's Social Security Number:	Phone Number:
E-mail address:	Cell Phone Number:
<b>PRIMARY INSURANCE:</b>	<b>SECONDARY INSURANCE:</b>
Employer:	Employer:
Under Whose Name:	Under Whose Name:
Social Security Number:	Social Security Number:
Date of Birth:	Date of Birth:
<b>FOR OFFICE USE ONLY</b>	
Deductible Met:    Y / N      \$	Deductible Met:    Y / N      \$
Oral Surgery %:                  Prevent %:	Oral Surgery %:                  Prevent %:
MAX\$:                  USED\$:                  AVAIL\$:	MAX\$:                  USED\$:                  AVAIL\$:
PPO:                  Spoke to:	PPO:                  Spoke to:
PANO:                  CONS:	PANO:                  CONS:
Pre-Authorization Required: Y / N	Pre-Authorization Required: Y / N
Waiting Period: Y / N      Claims Pending: Y / N	Waiting Period: Y / N      Claims Pending: Y / N
GA: Y / N                  W/One tooth:	GA: Y / N                  W/One tooth:
Group #                  Effective Date:	Group #                  Effective Date:
Insurance Address & Phone Number:	Insurance Address & Phone Number:
Date Verified:	Date Verified:
0363-                          6010-_____	0363-                          6010-_____
4263-                          4266-_____	4263-                          4266-_____
9610-                          7953-_____	9610-                          7953-_____