Insurance Verification Form TID 593287067 NPI 1720008121

Date_____ Appt Date_____ Patient_____

SS#_____ ID#_____ DOB_____

Address_____

PH# _____ WK#_____ O#_____

Referred By: _____ Pre-Med? Y?N Why _____

Blood Thinners? Y/N ___ Name of insured:_____

Ins'dSS# _____ DOB_____ Relationship to Pt:_____

Insurance Name:_____ Employer:_____

Group# _____ Phone# _____

Claims Address_____

Payer ID#_____

Effective: _____

Spoke with: _____ Time: _____

Please circle answer or fill in the blank

PPO Plan?_____ Maximum: _____ Deductible:_____ Calendar Year? _____

Preventative: _____% Basic:_____% Major:_____%

Cleanings ___12mo/Year/6mo Exams_____12mo/Year/6 mo

Bitewing X-rays Freq:____12mo/Year/6mo Panoramic/Full Mouth X-rays: 2 yr/3yr/5yr___ %

Flouride: Freq: 12mo/year/6mo Age limit____ Sealants: Freq:_____ Age limit_____

FMD (D4355)_____% Freq _____ Perio Maint: (4910) either/in addition to:_____%

Scaling/Root Planing (4341) 4 or 2 quads same day: _____% Freq:_____

Endodontics: Basic/Major Perio: Basic/Major Nightguard 9944/9945 Y/N _____%

Oral Surgery (7240) _____% Submit to Medical 1st Y/N

Replacement: Crown_____ Bridge _____ Denture_____ Pay on: Prep/Seat

MTC: Y/N Waiting Period _____ Implants:_____%