Dental Insurance Verification Form

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Dental Insurance Form

We need your **DENTAL** insurance information, NOT your medical insurance.

Primary Dental Insurance Information

Is the patient covered under a dental insurance plan? *

(•) Yes ( ) No

Is the patient the dental insurance policy holder? *

( ) Yes, the patient is the policy holder (e.g. subscriber)

( ) No, the patient is a dependent

Patient's First Name *

Patient's Last Name *

Patient's Date of Birth *

__/__/____

Select Primary Dental Insurance Provider *

-Select Insurance Provider-

[ ] Can't find your insurance provider in the list? Check this box and manually enter the provider name in the field above.

ID / Member # *

Group # *

Plan (e.g. PPO, DHMO, etc.)

Please attach a picture of your dental insurance card.
Make sure the photo is in focus and not blurry.

Front of Dental Insurance Card

Drop files to attach, Use Camera, or browse

Back of Dental Insurance Card

Drop files to attach, Use Camera, or browse

Secondary Dental Insurance Information

Is the patient covered by a secondary dental insurance plan? *

( ) Yes (•) No