Insurance Verification Form

As a service to our patients, we will file your dental insurance. However, you are responsible for all communication with your insurance company except for additional information required of this office pertaining to specific procedures. **Please complete this form and bring it to your New Patient Appointment.** Also, please understand that dental insurance is intended to cover some, but not all, of the cost of your dental care, and may include a deductible, which might need to be collected at your appointment.

Patient Name: _____ Patient's Date of Birth: _____/_____/_____

Policy Holder's Name: _____ Relationship to Patient: _____

Policy Holder's Date of Birth: _____/_____/_____ Social Security Number #: _____/_____/_____

Policy Holder's Employer: _____

Dental Insurance Company: _____

Group#: _____ Member #: _____

AUTHORIZATION

I certify that I am covered by _____ Insurance Company and I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, weather manual or electronic.

Signature:_____ Date: _____/_____/_____