INSURANCE VERIFICATION COVER SHEET

Members Name: _____

Members S.S.# or I.D: _____ D.O.B. _____

Patients Name: _____ Telephone #: _____ D.O.B. _____

Type of Insurance: _____ Employer: _____

Group #: _____ Other Insurance (Husband or Wife) ☐ Yes ☐ No

Eligibility Date: _____ Calender / Yearly Max: _____ Usage: _____

Deductible: _____ Family Coverage: _____

Are Deductibles waived on preventive? Yes_____ No_____

Preventive: _____ History: _____

Basic: _____ Frequency: _____

Major: _____ Missing Tooth Exclusion _____

Date of previous FMS: _____

Are Sealants covered? _____

Mailing Address of Insurance: _____

Other Insurance: _____