



## Patient Verification of Insurance

Dental Insurance providers will let us submit your claim information for dental treatment. However, they will not communicate with us about your policy details.

Your optimal oral health is our primary objective and as such, we will schedule appointments to achieve this goal.

Your Name: \_\_\_\_\_ Policy Holder (if other): \_\_\_\_\_

Birthdate: \_\_\_\_\_ Employer: \_\_\_\_\_  
Day/Month/Year

Insurance Co: \_\_\_\_\_ Group # \_\_\_\_\_ ID/Cert#: \_\_\_\_\_

Coverage period? Jan – Dec  Yes  No      % of Coverage: \_\_\_\_\_ (Basic) \_\_\_\_\_ (Major)

Yearly Maximum: \$ \_\_\_\_\_ (Basic) \$ \_\_\_\_\_ (Major)

Frequency Limitations? \_\_\_\_\_

If you have more than one insurance plan, please complete two separate forms. This form can also be found online at [driftwooddental.com](http://driftwooddental.com)

Completed forms may be emailed to [hygiene@driftwooddental.com](mailto:hygiene@driftwooddental.com) or please bring with you at your next appointment. Thank you.