



## DENTAL INSURANCE VERIFICATION

PATIENT'S NAME \_\_\_\_\_ DOB \_\_\_\_\_

INSURED'S NAME \_\_\_\_\_ DOB \_\_\_\_\_

INSURED'S ADDRESS \_\_\_\_\_

INSURED'S SS# \_\_\_\_\_

INSURED'S ID# \_\_\_\_\_

EMPLOYER: \_\_\_\_\_

INSURANCE CO: \_\_\_\_\_ PHONE \_\_\_\_\_

INSURANCE CO ADDRESS: \_\_\_\_\_

\_\_\_\_\_

GROUP # \_\_\_\_\_ If Child, place of residence:    Mother    Father

Is there a Court Order regarding Child's residence?    Yes    No

If YES, please bring copy of Court Order