# Dental Practice Insurance Verification Form

**Practice Information**

Practice Name: _____

Provider Name: _____

Contact Number: _____ Email: _____

**Patient Information**

Name: _____

Date of Birth: _____ Gender: [ ] Male [ ] Female

Insurance ID Number: _____

**Insurance Verification Checklist**

| Coverage Type | Covered | Not Covered | Notes |
|---|---|---|---|
| Preventive Services | [ ] | [ ] | |
| Restorative Procedures | [ ] | [ ] | |
| Orthodontic Treatment | [ ] | [ ] | |
| Emergency Visits | [ ] | [ ] | |

**Additional Notes**

_____

**Authorized By**

Practice Representative: _____

Signature: _____ Date: _____