# Interactive Dental Insurance Verification Form

**Patient Details**

Name: _____

Date of Birth: _____

Gender: [ ] Male [ ] Female

Phone Number: _____ Email: _____

**Insurance Provider Information**

Provider Name: _____

Policyholder Name: _____

Insurance ID Number: _____

**Coverage Verification**

| Service Type | Covered | Limitations | Additional Notes |
|---|---|---|---|
| Routine Cleaning | [ ] | | |
| Cavity Fillings | [ ] | | |
| Crowns/Bridges | [ ] | | |
| Wisdom Teeth Extraction | [ ] | | |

**Additional Instructions**

1. Attach a copy of the insurance card (front and back).
2. Contact the provider for confirmation of benefits.

**Signature**

Patient/Guardian Signature: _____ Date: _____