Pediatric Dental Insurance Verification Form

Patient Information

Child's Name: _____

Date of Birth: _____

Gender: [ ] Male [ ] Female

Parent/Guardian Name: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Phone Number: _____ Email: _____

Insurance Information

Insurance Company Name: _____

Policyholder Name: _____

Policy Number: _____

Group Number: _____

Contact Number for Claims: _____

Coverage Details

Is pediatric dental care covered? [ ] Yes [ ] No

Annual Deductible: $_____

Maximum Coverage Limit: $_____

Authorization Information

Is pre-authorization required? [ ] Yes [ ] No

Required Documents for Claim: _____

Acknowledgment

I confirm that the above information is accurate to the best of my knowledge.

Parent/Guardian Signature: _____ Date: _____