INSURANCE VERIFICATION FORM

As a courtesy to our patients, we file and accept payment from your insurance company. We are providing you with this form and ask that you call your insurance company to ask them the following questions so we can estimate what your payment should be at the time of service. We understand that calling your insurance company & filling out this form may be inconvenient for you. Please understand that it is our way of educating our patients as to what their plan does and does not cover. Dental insurance is intended to cover some, but not all, of the cost of your dental care. ***We cannot stress enough that insurance payment is not, and has never been, a guideline for quality care***.

Policy Owner's Name _____Patient Name _____

Policy Owner's Address (if different than pt's) _____

Policy Holder's DOB _____ SSN_____ Relationship to Patient_____

Policy Owner's Employer _____ Ins. Co. Name/Address _____

_____ Phone No._____ Group #_____

PLEASE CALL THE 1-800# ON YOUR CARD TO COMPLETE THIS FORM & HAVE YOUR BENEFITS FAXED TO OUR OFFICE @ 828-299-0550

Calendar or fiscal year: _____ Policy effective date:_____ UCR or Fixed Rates? _____

Yearly Maximum $_____ Deductible $_____ Applies to preventative? Yes__ No__

Applies to diagnostic? Yes __ No __ _____

Coverage: At what percentages do you cover the following?

Preventative _____% Diagnostic _____% Basic Restorative _____% Major Rest. _____%

Endo _____% Basic Perio _____% Major Perio _____% Oral Surg Basic_____% Oral Surg Major _____%

Dentures/Partials _____% Implants _____% Implant Crowns _____%

Sealants Yes __ No __ _____% Molars and Pre molars? _____ Up to what age? _____

Nitrous Oxide (code D9230) _____% Conscious sedation (code D9248) _____%

Waiting Periods? Yes __ No __ If so, how long? _____

Missing Tooth Clause? Yes __ No __ Replacement time for partials, dentures, crowns, bridges? Yes __ No __

Do you downgrade for posterior composite fillings? Yes __ No __

FREQUENCY: Cleanings _____Bitewings _____FMX/Panoramic _____

I certify that I am covered by the insurance company listed above. I assign directly to Dr. White all insurance benefits otherwise payable to me. I hereby authorize Dr. White to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____

Signature Date