ORAL SURGERY AND IMPLANT CENTER OF OCEAN PARKWAY
VERIFICATION OF DENTAL COVERAGE

Patient - Please complete the following:

Date: _____

Patient's Name: _____

Insured's Name: _____

Insured's Social Security #: _____

Employer's Name: _____

Employer's Telephone: _____

Insurance Company: _____

Signature: _____

Please do not write below line. For office use only.

Insurance Co. Telephone _____

Spoke To: _____

Effective Date of Insurance: _____

Insurance Based Upon ☐ Calendar Year ☐ Fiscal Year of _____

Yearly Maximum: _____

Amount Used To Date: _____

Amount of Deductible: $_____ ☐ Paid ☐ Not Paid

Payment By: ☐ Fee Schedule or ☐ Rates: ____% Preventive, ____% Basic

Pay for g.a.? ☐ No ☐ Yes _____%

Waiting Period: ☐ No ☐ Yes _____

Accept signature on file? ☐ No ☐ Yes

Procedures Covered: _____

_____

_____