

# Insurance Verification Form

Please contact your insurance provider and fill out the form below. Once completed please return to us in person, or via fax/ email to either of our locations. This form is completely confidential.

## The Smile Zone

8742 109 St NW, Edmonton, AB

T6G 1E9

Ph: (780) 989-5733

Fax: (780) 989-5730

E: [smilezone.reception@gmail.com](mailto:smilezone.reception@gmail.com)

## Urban Smiles Family Dentistry

8003 - 104 Street NW

Edmonton, AB T6E 4E3

Ph: (780) 989-6030

E: [reception@urbansmiles.ca](mailto:reception@urbansmiles.ca)

Patient name: \_\_\_\_\_

D.O.B. (mm/dd/yyyy): \_\_\_\_\_

### Primary Insurance Company

Policy holder name: \_\_\_\_\_

D.O.B. (mm/dd/yyyy): \_\_\_\_\_

Relationship to patient (*circle one*): **SELF** **PARENT/ GUARDIAN** **SPOUSE** **OTHER:** \_\_\_\_\_

Insurance company: \_\_\_\_\_

Effective Date (mm/dd/yyyy): \_\_\_\_\_

Policy No: \_\_\_\_\_

I.D./ Certificate No: \_\_\_\_\_

Annual deductible: \_\_\_\_\_

Annual maximum: \_\_\_\_\_

Combined annual maximum (please circle): **YES** **NO**

Preventative: \_\_\_\_\_ % Basic: \_\_\_\_\_ % Major: \_\_\_\_\_ % Ortho: \_\_\_\_\_ %

Recall exam: \_\_\_\_\_ Per \_\_\_\_\_ Year/ months

Bitewings: \_\_\_\_\_ Per \_\_\_\_\_ Year/ months

Scaling units: \_\_\_\_\_ Per \_\_\_\_\_ Year/ months

Prophy: \_\_\_\_\_ Per \_\_\_\_\_ Year/ months

Fluoride: \_\_\_\_\_ Per \_\_\_\_\_ Year/ months

Sealants: \_\_\_\_\_ Per \_\_\_\_\_ Year/ months

Bruxism appliance: \_\_\_\_\_ % Per \_\_\_\_\_ Year (s)

### Secondary Insurance Company (if applicable)

Policy holder name: \_\_\_\_\_

D.O.B. (mm/dd/yyyy): \_\_\_\_\_

Relationship to patient (*circle one*): **SELF** **PARENT/ GUARDIAN** **SPOUSE** **OTHER:** \_\_\_\_\_

Insurance company: \_\_\_\_\_

Effective Date (mm/dd/yyyy): \_\_\_\_\_

Policy No: \_\_\_\_\_

I.D./ Certificate No: \_\_\_\_\_

Annual deductible: \_\_\_\_\_

Annual maximum: \_\_\_\_\_

Combined annual maximum (please circle): **YES** **NO**

Preventative: \_\_\_\_\_ % Basic: \_\_\_\_\_ % Major: \_\_\_\_\_ % Ortho: \_\_\_\_\_ %

Recall exam: \_\_\_\_\_ Per \_\_\_\_\_ Year/ months

Bitewings: \_\_\_\_\_ Per \_\_\_\_\_ Year/ months

Scaling units: \_\_\_\_\_ Per \_\_\_\_\_ Year/ months

Prophy: \_\_\_\_\_ Per \_\_\_\_\_ Year/ months

Fluoride: \_\_\_\_\_ Per \_\_\_\_\_ Year/ months

Sealants: \_\_\_\_\_ Per \_\_\_\_\_ Year/ months

Bruxism appliance: \_\_\_\_\_ % Per \_\_\_\_\_ Year (s)

*Dental plans are a valuable component of extended health benefits and are designed to offset the cost of dental treatment. Treatment recommendations are based on your dental health needs, not dictated by your dental coverage.*

*I, \_\_\_\_\_, verify that the information stated above is correct and that I will be responsible for any charges that my insurance company does not cover. This may include co-payments (or deductibles), charges over the "allowed amount" or other materials/fees that are not covered under my insurance policy.*

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***Patient's signature / guardian***

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***Date***