Dental Insurance Verification

If you have a card with information about your insurance carrier please feel free to send us a copy of the front and the back of the card, or you may fill in the blanks below and forward this back to our office.

Policy holder Employer: _______________________________________

Policy holder name: ____

Policy holder date of birth: _____________________________________

Policy holder SSN*/or Member ID #: ____

*in some cases the SSN of the policy holder is the member identification number for your insurance carrier (you may look at your card for other personalized pieces of information such as an ID #)

* If you are uncomfortable providing this information via fax or e-mail you may contact our office directly and give this information to Lisa, our insurance benefits coordinator.

Patient Name*: ____

* If patient is same as policy holder, leave this section blank.

Patient date of birth: ____

Name of Dental Insurance Company: ______________________________

Customer Service number for Insurance: ___________________________

** If you need assistance completing this form please contact our office via phone, fax or email.

Lakeside Dental

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