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

Urban Smiles Family Dentistry
8003 - 104 Street NW
Edmonton, AB T6E 4E3
Ph: (780) 989-6030
E: 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.

_____ _____

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