

Insurance Verification of Coverage

Dr. Alex J. Johnson, D.M.D., M.S. Date _____

Patient Name _____ D.O.B. _____

Insured Name _____ D.O.B. _____

Insured Address _____ SS# _____

Insured Employer _____

Insured's Personal ID# _____ Group # _____

Insurance Company Name _____

Insurance Company's Address _____

Insurance Company's Phone # _____

OFFICE USE ONLY

Insurance Effective Date _____ Age Limit _____

Max Amount \$ _____ Percent _____ Deductible _____

Portion Used _____

Payments - Monthly / Quarterly / In Full _____ % Of Initial Pmt _____

Automatic to provider Y / N

Pre-estimate Required Y / N

Payor # _____

Waiting Period _____

To ensure benefits are verified prior to your appointment, please feel free to fax this form to our office at **727-784-7644**.