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.**