annette williamson dds & associates
SMILES ON BROADWAY

INSURANCE INFORMATION

PATIENT'S NAME _____

Primary Insurance

Name of insured _____

Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security _____ Insured birth date _____

Employer _____

Insurance Company _____

Address _____

City/State/Zip _____

Insurance Company phone _____

ID# _____ Group # _____

Secondary Insurance

Name of insured _____

Relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other

Insured Social Security _____ Insured birth date _____

Employer _____

Insurance Company _____

Address _____

City/State/Zip _____

Insurance Company phone _____

ID# _____ Group # _____

I authorize the insurance company listed on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges. I understand that payment in full is due at the time of treatment, unless prior arrangements have been approved. I understand that any insurance is a contract between myself and the insurance company and that I am solely responsible for complying with the terms of my contract. I understand that any attempts by the office to submit information to my insurance company or to obtain benefits therefrom is only a courtesy and Dr. Williamson is not assuming any responsibility for complying with the terms of my insurance policies, nor am I relying on Dr. Williamson's actions.

Signature _____ Date _____

OFFICE
219.663.4200

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FAX
219.663.4700