DAVID WICKNESS, DMD

BELLE MEADE • NASHVILLE

INSURANCE INFORMATION

Name of insured _____ Date of birth _____

Address _____ City/State/Zip _____

Home phone _____ Work phone _____ SS# _____

Employed by _____

Address _____ City/State/Zip _____

Insurance contact person or department _____

Your relationship to insured _____

If patient is a minor, name and address of responsible party for payment _____

_____ Relationship _____

Primary insurance company name _____

Address _____ City/State/Zip _____

Phone _____ Group # _____ Policy # _____

Do you have secondary dental insurance coverage? Yes ____ No ____

If so, with whom? _____

COVERAGE

Preventative _____ Cal. Year _____

Basic _____ Deductible _____

Major _____ Maximum _____

Ortho _____ Other _____

Acknowledgment _____

I hereby certify that the above information is correct. It is the patient's responsibility to file their own secondary dental insurance coverage. I understand that insurance may not cover all costs of treatment and I agree to pay my balance, 1% interest per month, and/or all costs of collection incurred by David Wickness, DMD. A $50.00 fee is charged for appointments canceled or broken within 24 hours advance notice.

Signature _____ Date _____