Waterman
Oral and Maxillofacial Surgery

Tyler E Nelson, DMD, MD
(707) 428-5427 Fax: (707) 428-1922
watermanomfs@gmail.com
2801 Waterman Blvd. Ste. #240
Fairfield, CA 94534

INSURANCE INFORMATION

(Please print clearly)

Patient's Name: First ___________________________ Last ______________________________

Primary Dental Insurance: **Policy Holder's Information:**

Name of Insurance ____________________________ Ins Phone # _________________________

Policy Holder's Name: First _____________________ Last _______________________________

Social Security __________-_______-_____________ Date of Birth _____/_____/_____

Home Phone (_______) ________ -___________ Work Phone (_______) ________ -___________

Address ___________________________ City ______________ State __________ Zip _______

Relationship to Patient __________________________________

Primary Dental Insurance: **Policy Holder's Information:**

Name of Insurance ____________________________ Ins Phone # _________________________

Policy Holder's Name: First _____________________ Last _______________________________

Social Security __________-_______-_____________ Date of Birth _____/_____/_____

Home Phone (_______) ________ -___________ Work Phone (_______) ________ -___________

Address ___________________________ City ______________ State __________ Zip _______

Relationship to Patient __________________________________

What is your Medical Insurance? ____

If Kaiser, what is your medical record number? ______________________________________

We can bill most insurance plans. It is your responsibility to make sure that we receive the correct information. We file insurance claims as a courtesy to our patients. If your insurance company fails to pay on the claim within 60 days for any reason, you will be billed for the full balance. If your insurance pays more than is due, then a refund will be sent to you. Insurance coverage is a contract between you, your employer, and your insurance company and we will not be involved in any disputes regarding deductibles, co-payments, covered charges, etc., other than to supply them with information given to us by you. We also cannot guarantee that the information given to us by your insurance company regarding covered benefits is correct. If your insurance company pays directly to you, we require that the cost of the treatment be paid in full on the day of service.

YOU ARE ALWAYS RESPONSIBLE FOR THE PAYMENT OF YOUR ACCOUNT REGARDLESS OF WHAT YOUR INSURANCE COMPANY MAY PAY.

PATIENT'S SIGNATURE: ________________________ DATE: ______________________

(Parent or legal guardian to sign, if under 18)