Waterman
Oral and Maxillofacial Surgery

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PAYMENT INFORMATION

PERSON RESPONSIBLE FOR PAYING THIS ACCOUNT:

☐ Self ☐Spouse ☐Parent ☐Other____________________________

First______________________M.I.______Last:_________________________Phone number_________________

Home address:____

Apt.#__________City____________________State_____Zip__________________

Social security_____________________________Male ☐ Female ☐ Date of Birth__________________

Mailing address, if different____

Primary Dental Insurance	**Secondary Dental Insurance**
Insurance Name_________________________________	Insurance Name__________________________________
Phone Number__________________________________	Phone Number___________________________________
Subscriber name First: ___________________________	Subscriber name First: ______________________________
Last____	Last: ____
Subscriber SSN/ID______________________________	Subscriber SSN/ID_________________________________
Date of Birth__________________________________	Date of Birth_____________________________________
Mailing Address________________________________	Mailing Address__________________________________
____	____
Relationship to patient__________________________	Relationship to patient______________________________

Medical Insurance Company?___________________________________**If Kaiser MR#**____________________

We can bill most insurance plans. We file insurance claims as a courtesy to our patients. Insurance coverage is a contact between you, your employer, and your insurance company. We will not be involved in any disputes. We also cannot guarantee that the information provided to us by your insurance is correct.

You are always responsible for the payment of your account regardless of what your insurance may pay.

Patient signature____Date______________________

(Parent or legal guardian if under 18)