

INSURANCE INFORMATION

Robert D. Westerman, D.D.S.

Insurance Holder's Name Sex Birthday Soc. Sec. #

Spouse's Name Sex Birthday Soc. Sec. #

Dependent's Name (last name if different than yours) Sex Birthday

1. _____

2. _____

3. _____

4. _____

Insurance Holder's Employment _____

Insurance Company Name Address City State Zip

Any numbers that may be required (such as: Group #, Employee #, etc.)

If you have additional coverage, please complete below.

Insurance Holder's Name Sex Birthday Soc. Sec. #

Employment _____

Insurance Company Name Address City State Zip

Any numbers that may be required (such as: Group #, Employee #, etc.)

I authorize release of any information relating to my claim.

Signature _____

I authorize payment directly to Dr. Westerman.

Signature _____

I understand that all fees not paid by insurance are my responsibility.

Signature _____

Witness _____ Date _____

Note: If you have an insurance card, please give it to the receptionist so she can make a photocopy which will help in speeding your insurance claim.