



2571 ANTHEM VILLAGE DRIVE SUITE 5  
 HENDERSON, NEVADA 89052  
 702.454.7704

Todd W. Newton, D.D.S.  
 Corry L. Timpson, D.D.S.  
 Robert W. Nisson, D.D.S.

**DENTAL INSURANCE INFORMATION**  
**PRIMARY DENTAL INSURANCE**

Whom is the insurance holder? \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
 (Required)

Address (if different from patient's) \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
 (List employer if retirement employer provides dental insurance coverage)

Employers Address \_\_\_\_\_ Employers Phone \_\_\_\_\_

Insurance company & address \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber ID# \_\_\_\_\_ Local # \_\_\_\_\_

<b>Office employee use only</b>	Effective Date _____	Preventive _____	Yearly Max _____
History: Last Prophy _____	Waiting Periods _____	Basic _____	Calender Yr or _____
Last FMX _____ Pano _____	Missing tooth Clause _____	Major _____	Deductible _____
Last BWX _____	Ortho coverage _____ To Age _____	Endo _____ Perio _____	*Note _____
	Fluoride _____ To Age _____	Veneers _____	Implants _____

\*\*\*\*\*  
**SECONDARY DENTAL INSURANCE**  
 \*\*\*\*\*

Whom is the insurance holder? \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Birthdate \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_  
 (Required)

Address (if different from patient's) \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Subscriber employed by \_\_\_\_\_ Occupation \_\_\_\_\_

Employers Address \_\_\_\_\_ Employers Phone \_\_\_\_\_

Insurance company & address \_\_\_\_\_

Contract # \_\_\_\_\_ Group # \_\_\_\_\_ Subscriber # \_\_\_\_\_ Local # \_\_\_\_\_

<b>Office employee use only</b>	Effective Date _____	Preventive _____	Yearly Max _____
History: Last Prophy _____	Waiting Periods _____	Basic _____	Calender Yr or _____
Last FMX _____ Pano _____	Missing tooth Clause _____	Major _____	Deductible _____
Last BWX _____	Ortho coverage _____ To Age _____	Endo _____ Perio _____	*Note _____
	Fluoride _____ To Age _____	Veneers _____	Implants _____

**ASSIGNMENT OF BENEFITS:** I hereby authorize and request my insurance company to pay directly to Anthem Village Dental the amount due on my claim for services rendered to me or my dependant. I further agree that should the amount be insufficient to cover the entire dental expense, I will be responsible for payment of the difference; and if the nature of the liability be such that it is not covered by the policy, I will be responsible to Anthem Village Dental for payment of the entire bill.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_