



**WARM  
SPRINGS  
DENTAL**

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## INSURANCE INFORMATION

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### PRIMARY INSURANCE

Who is the insurance holder? \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Birth date \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

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

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

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

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_

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

### SECONDARY INSURANCE

Who is the insurance holder? \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Birth date \_\_\_\_\_ Soc. Sec. # \_\_\_\_\_

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

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

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

Business Address \_\_\_\_\_ Business Phone \_\_\_\_\_

Insurance Company \_\_\_\_\_

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

**ASSIGNMENT OF BENEFITS:** I hereby authorize and request my insurance company to pay directly to Warm Springs Dental the amount due on my claim for services rendered to me or my dependent. 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 Warm Springs Dental for payment of the entire bill.

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