



Insurance Information

(This information MUST be completed in full in order to bill your insurance.)

***We will attempt to verify your insurance coverage; however, it is your responsibility to familiarize yourself with your insurance benefits and keep us updated on any changes throughout treatment.

Primary Insurance Company

Insurance Company name _____
Insurance Company Address _____
Insurance Company Phone Number _____
Employer's Name _____ Phone number _____
Employer's Address _____
Name of insured _____ Phone number _____
Occupation _____
Home Address _____
Date of Birth ____/____/____ Social Security Number _____
Relationship to Patient: _____ Self _____ Spouse _____ Parent _____ Other

Secondary Insurance Company

Insurance Company name _____
Insurance Company Address _____
Insurance Company Phone Number _____
Employer's Name _____ Phone number _____
Employer's Address _____
Name of insured _____ Phone number _____
Occupation _____
Home Address _____
Date of Birth ____/____/____ Social Security Number _____
Relationship to Patient: _____ Self _____ Spouse _____ Parent _____ Other

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