West Tenn Pediatric Dental
John C. Williams, D.D.S., M.S.
Jennifer W. Welch, D.M.D
206 Murray Guard Drive, Jackson, TN 38305
731-664-0080/800-237-7011

INSURANCE INFORMATION

Patient name: _____ Patient birthdate _____
first m.i. last MM/DD/YYYY
Relationship to employee: ☐ self ☐ child ☐ other _____ Sex _____male _____ female

If full time student: School _____ City _____

PRIMARY INFORMATION

Insurance Carrier name and address: _____
_____
_____

Employee/Subscriber name and mailing address: _____
_____

Employee/Subscriber SS# or ID# _____ Birthdate _____
Employer Name _____ Group number _____

SECONDARY INFORMATION

Insurance Carrier name and address: _____
_____
_____

Employee/Subscriber name and mailing address: _____
_____

Employee/Subscriber SS# or ID# _____ Birthdate _____
Employer Name _____ Group number _____

I hereby authorize West TN Pediatric Dental Group, Inc. to affix my name to all insurance submissions, documents, and/or information requested by my insurance company(s) relating to any and all dental benefits due to me and my dependents.

I also authorize payment of dental benefits otherwise payable to me, directly to my doctor as listed above. I agree to be held responsible for all charges and services not paid by my insurance company.

_____ _____
Date Signature of Insured