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**ATTENTION ALL PATIENTS!**

A current copy of either an insurance card or form, completely filled out with mailing address, phone number and group number must be present on your first visit or we will not be able to verify your benefits or bill your insurance on your behalf.

**WE BILL YOUR INSURANCE AS A  
COURTESY TO YOU.**

We cannot be expected to know your insurance benefits and limitations. If you have any question regarding your coverage, please call your carrier.

Responsible Party Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Please sign and return at your appointment. Thank you.