MADISON FAMILY DENTISTRY

GENERAL & COSMETIC

LANCE D. DILLON, M.S., D.M.D.

Patient Information

Patient LAST Name: ______________________ FIRST Name: ________________________ D.O.B_____
Social Security Number____
__male __female __single __married __divorced Student Yes__ No__

Address____ City_________________________
State________________ Zip code_____________ Telephone________________(home)
________________(work) _________________(cell)

Email____

Employer____

Dental Insurance____

Dental Insurance Group Number__________________ Policy Number_________________

Subscriber's Name____DOB________________

Social Security number____

Insurance Company's address ____

Insurance Company's tele.number____

How did you hear about our practice so we can thank them?____

Responsible Party (if other than parent)____

Last Name______________________First Name______________________DOB_____________

Address____ City_________ State_____ Zip_____________

Telephone (home)_____________Work_____________________ Cell__________________

Email____

Employer_________________________________Occupation______________________________

Social Security Number_____________________Dental Insurance _________________________

Group_________________________________Plan_______________________________________

Emergency Contact's Last Name___________________________First Name________________
Telephone no. (home)_______________(work)________________(Cell)_____________________

I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care. I authorize the release of any information concerning my (or my child's) health care, advice, and treatment provided for the purpose of evaluating and administrating claims for insurance benefits.I hereby authorize payment of insurance benefits directly to the dentist or dental group, otherwise payable to me. I understand that my dental care insurance carrier or payer of my dental benefits may pay less than the actual bill or services. I understand I am financially responsible for payments in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payments of services not paid, in whole or in part by my dental care payer. Signature____Date_________________________________

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