Lansdowne Family & Cosmetic Dentistry

WELCOME

Please take a few minutes to complete the following confidential information.
If you have any questions we'll be glad to help you.

Patient Information

Date _____ Social Security # _____ Birth Date _____
Last Name _____ First Name _____ Home Phone _____
Address _____
City _____ State _____ Zip _____
☐ Male ☐ Female Age _____ ☐ Single ☐ Married ☐ Divorce ☐ Widowed
E-Mail Address _____ Cell Phone _____
Where can you be reached during the day? ____ Home ____ Work ____ Cell ____ E-mail
Patient Employed by _____ Occupation _____
Business Address _____ Business Phone _____
Whom may we thank for referring you? _____
Person to contact in case of an emergency _____ Phone _____
Closest relative not living with you _____ Phone _____
Address _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance with _____
Name of Insurance Company

And assign directly to Dr. Ellington all benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance for myself and/or minor children. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

Date _____ Signature _____

Primary Dental Insurance

Employee (Subscriber) _____
Insurance Company _____ Group # _____
Employer _____
Business Address _____ Phone _____
Occupation _____
Employee date of birth _____ Social Security # _____ Date employed _____