Michael J. Amodeo, D.D.S., Inc
Christy D. Lam, D.D.S., Inc
Gordon H. Dixon, D.D.S., M.S., Inc

Christopher J. Eitzen, D.D.S., Inc
Martin H. Thurston, D.D.S., M.S., Inc

# Dental Insurance Information

## Patient

○ Pediatric Dentistry ○ Orthodontics ○ Both

First Name | M.I. | Last Name | Date of Birth | ○ M ○ F

Address | City | State | Zip Code | Phone

## Primary

Insurance Name | Effective Date | Employer

Insurance Address | City | State | Zip Code | Insurance Phone

(Subscriber) First Name | M.I. | Last Name | Date of Birth

Social Security# | Subscriber I.D. # | Group # | Relationship to Patient

**Is patient covered by another dental insurance plan?** ○ Yes ○ No

**Subscriber's Address ( If different than patient)**

Address | City | State | Zip Code | Phone

## Secondary

Insurance Name | Effective Date | Employer

Insurance Address | City | State | Zip Code | Insurance Phone

(Subscriber) First Name | M.I. | Last Name | Date of Birth

Social Security# | Subscriber I.D. # | Group # | Relationship to Patient

**Subscriber's Address ( If different than patient)**

Address | City | State | Zip Code | Phone

I hereby authorize payment of the dental benefits otherwise payable to me directly to the above named entity. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

**Signed (Subscriber/Parent)** **Date**