Dr. Paul L. Dionne, DMD

200 Highland Ave, Suite 260
Glen Ridge, NJ 07960
973-748-7790
Fax: 973-748-7796

Dental Insurance Information

Patient Name: _____ Date of Birth: _____
Patient's relationship to subscriber (ie. Spouse, Self, Child..): _____

Subscriber's Name: _____ Date of Birth: _____
Subscriber Social Security #: _____
Address: _____ City/State/Zip _____
Employed by: _____
Address: _____ City/State/Zip _____

If patient is a minor, name and address of responsible party for payment: _____
_____ Relationship: _____

Primary Insurance Company Name: _____
Address: _____ City/State/Zip _____
Phone: _____ Group #: _____ Policy #: _____

Secondary Insurance:
Do you have secondary dental insurance coverage? ____ If yes, with whom: _____
_____
Secondary Ins. Subscriber Name: _____ Date of Birth: _____
Subscriber Social Security #: _____
Address: _____ City/State/Zip _____
Employed by: _____
Address: _____ City/State/Zip _____

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I hereby assign and direct payment of the dental benefits otherwise payable to me, directly to Dr. Paul Dionne, DMD.

I hereby certify that the above information is correct. I understand that insurance may not cover all costs of treatment and I agree to pay for all charges for dental services and materials not paid by my dental benefits plan, 1% interest/month, and/or all costs of collection incurred by Dr. Paul L. Dionne, DMD. A $50 fee is charged for appointments cancelled or broken without 24 hours advance notice.

Signature: _____ Date: _____