MARILEE R. DIXON, D.D.S.

GENERAL DENTISTRY
2801 WOOTEN BOULEVARD, BUILDING B
WILSON, NC 27893

SUZANNE S. HOLMES, D.D.S.

Today's Date_____

Patient's Name _____
Last First MI Preferred Name

Confirm Appt. by:

Mailing Address _____ Street

_____ Rural Route

_____ City State Zip Code

Phone ( ) _____ Home ☐

( ) _____ Parents Work # ☐

( ) _____ Mobile ☐

Birthdate_____ SSN_____

Parent's Name _____

Parent's Employer _____

Parent's SSN _____ Parent's Birthdate _____

Parent's Work Phone _____ Ext. _____

Who is the person responsible for payment? _____

Whom may we thank for this referral? _____

Does this patient have any of the following insurance plans? ☐ Medicaid ☐ NCHealthchoice

Dental Insurance Information

Employee Name _____ Group or ID# _____

Employee Birthdate _____ Employer Name _____

Employee SSN _____ Employer Phone _____

Relation to Patient _____ Employer Contact _____

Employee Address _____ Employer Address _____

_____ _____

_____ _____

As a courtesy to our patients, we will file your insurance claims, if all needed information is provided to us the day of service. I authorize release of any information conerning my (or my child's) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I authorize release of any information concerning my (or my child's) health care, advice and treatment to another dentist. I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to me. I understand that my dental insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payments in full on all accounts. By signing this statement, I agree to be responsible for payment of services not paid, in whole or part by my dental payor, within 60 days.

Patient/Parent/Guardian Signature _____ Date _____