

PATIENT DATA SHEET

Last Name First Name Middle Initial

Mailing Address Physical Street Address

City State Zip Code

() () Home Phone Number Work Phone # & Ext Person to notify in Emergency

/ / Date of Birth Sex Social Security Number Marital Status

If College Student: School Name City Full or Part-time Student

Who referred you to our office?

Do you have dental insurance? Yes No

Do you have MaineCare(Medicaid)? Yes No

Regarding the Policy Holder

Name Employer

Address

Date of Birth Social Security #

Insurance Company Name

Insurance Company Address

Policy/Certificate Number Group Number

Effective from (date) to (date)

Please list all patients covered by this policy (first and last names):

- 1. 2. 3.

Please list secondary insurance information on the reverse side of this form.

If Patient Under 18 Years of Age, Name of Person Responsible for Payment

Address (if different from Patient) City State Zip

Payment is expected in full at time of service. Patients with dental insurance are expected to pay any co-payment at the time of service. We are not currently accepting any new MaineCare (Medicaid) patients. A billing charge of 18% per year will be charged on all accounts past due. We accept payment by cash, check or credit card.

Signature of Person Responsible for Payment

Date