



# Kennebunk Center for Dentistry

Kindness. Compassion. Dedication

## Patient Information

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
Email: \_\_\_\_\_ Contact Preference: \_\_\_\_\_  
(home, cell, email, etc.)  
Social Security #: \_\_\_\_\_  M  F Marital Status: \_\_\_\_\_  
Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Parent's Name (if child): \_\_\_\_\_ Spouse (if married): \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
Do we currently see other family members?  Y  N  
How did you hear about us? \_\_\_\_\_

## Dental Insurance Information

Are you enrolled in the Maine Care program?  Y  N  
Insurance Company: \_\_\_\_\_ Group #: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Subscriber Name: \_\_\_\_\_ DOB: \_\_\_\_\_  
Subscriber ID: \_\_\_\_\_ Relationship: \_\_\_\_\_

I UNDERSTAND THAT I AM RESPONSIBLE FOR MY ACCOUNT. I UNDERSTAND THAT KENNEBUNK CENTER FOR DENTISTRY IS NOT IN-NETWORK WITH ANY INSURANCE COMPANIES.

Kennebunk Center for Dentistry will submit to my dental insurance necessary information for reimbursement. I am responsible for the balance if my insurance claim is not paid within 60 days. I authorize the release of dental/medical histories to third-party payers and other health professionals. A late fee of \$35.00 will be applied to balances over 60 days. While we make every effort to remind you of your appointments, ultimately you are responsible for keeping your scheduled appointments. If you fail to keep your appointment or reschedule within 48 hours prior to your appointment, you will be charged a missed appointment fee. If you need financing for your dental treatment, we offer CareCredit.

### CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION:

By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. You have the right to read our notice of privacy practices before you sign this consent. We reserve the right to change our privacy practices as described. If we change our practices, we will issue a revised notice of privacy practices.

### CONSENT FOR TREATMENT:

I hereby authorize and direct Kennebunk Center for Dentistry to dental care for me or my child. I understand that I will be provided with answers to any questions which may arise during the course of treatment.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_