Patient Information

Patient Name: ______________________ Date of Birth: ______________________

Street Address: ____

City: ______________________ State: ____________ Zip: ______________________

Home Phone:____________ Work Phone:____________ Cell Phone:

Email Address: ______________________ Contact Preference *(email, cell phone, ~~etc~~)*:______________

Social Security Number: ______________ Gender: M F Other Marital Status:______________

Parent's Name *(if this form is for a child)*: ____

Spouse's Name *(if married)*:____

Employer: ______________________ Occupation: ______________________

Emergency Contact Name: ______________________ Relationship:

Emergency Contact Phone Number:______________________ ______________

Do we currently see other family members? Y N

How did you hear about us? ____

Dental Insurance Information

Insurance Company Name: ____

Group Number: ______________________ Employer: ______________________

Subscriber Name: ____

Date of Birth: ______________________ Subscriber ID: ____________ Payer ID#:____________

Relationship: ______________________ Dental Claims Address ______________________

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 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 provide 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 ______________________