Topsham Dental Arts

Patient Information

Whom may we thank for referring you to us? ____

Legal Name: Mr. Ms. Mrs. Miss Dr. _______________________________ Preferred Name _______________

Date of birth: __________________ Social Security Number: ________________________

Mailing address: Street: _______________________ City: _________________ State: ______ Zip: __________

Home phone: ___________________Cell phone: _________________ E-Mail: ___________________________

Which method of contact do you prefer? ______________________

Emergency Contact-Name: _____________________________ Relationship to Patient: ____________________

Home Phone: __________________ Cell Phone : ____________________________

Person financially responsible for this account, if other than patient

Name: __________________________________ Relationship to patient: __________________

Mailing Address: Street: ____________________________ City: ________________ State: ____ Zip: ________

Dental Insurance Information (If Applicable)

Patient Name: ____ Male Female

Name of Insured: ____ Policy #:_______________________

Insured's Birth Date: ________________ Social Security #: _________________ Group #: _______________

Patient's relationship to insured: Self Spouse Child Other

Name of Dental Insurance Company: __________________________ Telephone Number: ________________

Employer Name: ____

I authorize Topsham Dental Arts to release information including the diagnosis and the records of any treatment or examination rendered to me or my dependant during the period of such dental care to the insurance company. **Yes No**

I authorize my insurance company to pay benefits directly to the dentist, rather than to me. **Yes No**

I understand that my dental insurance may pay less than the actual fee for services rendered and agree to be financially responsible for payment of all services provided to myself and my dependants. **Yes No**

I understand that any fees not paid by my dental insurance within 30 days of service will become my responsibility. **Yes No**

Signature of patient, parent or guardian ___________________________________ Date ___________________