TAYLOR BROOK DENTAL ASSOCIATES, P.A.
PATIENT DATA SHEET

Last Name	**First Name**	**Middle Initial**	**Date of Birth**

Mailing Address:

Street/PO Box:_____

City:_____

State:_____ Zip:_____

Physical Address:

Street:_____

City:_____

State:_____ Zip:_____

(___)_____ Home Phone

(___)_____ Work Phone/Ext.

(___)_____ Mobile Phone

Social Security Number
_____-_____-_____

☐ Male ☐ Female

_____
Email Address

Preferred Communication
☐ Phone ☐ Text ☐ Email

Person(s) with whom TBDA may discuss your dental care:_____

Person to notify in case of emergency (Name/Phone Number):_____

I authorize TBDA to send my medical information to insurers and providers outside of the practice when necessary, to obtain payment for treatment rendered and for continuity of care.	I give permission to TBDA to leave medical information on my voice mail if I am unavailable.	If patient is under 18 years of age, responsible party: Name:_____ Address:_____ _____ Phone:_____
☐ Yes ☐ No	☐ Yes ☐ No	

How did you hear about us?
☐ Family Member
☐ Current Patient (name so we may thank them)_____
☐ Website
☐ Facebook
☐ Other:_____

INSURANCE INFORMATION

Please Note: WE ARE UNABLE TO ACCEPT MAINE CARE

Do you have dental insurance: ☐ No ☐ Yes (If yes please fill out information below)

PLEASE SHOW CARD AT CHECK IN

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In order to bill your insurance company, the following **MUST** be completed in **FULL**.

Regarding the Policy Holder:

Name:_____
Employer:_____
Street/PO Box:_____
City:_____
State:_____ Zip:_____
Date of Birth:_____
Social Security Number:_____

Regarding the Insurance Company:

Ins. Co. Name:_____
Ins. Co. Street:_____
Ins. Co. City:_____
Ins. Co. State:_____ Zip:_____
Policy/Certificate Number:_____
Group Number:_____
Effective from _____(date) to _____(date)

Please list all patients covered by this policy (First and Last Names):

_____ _____

_____ _____

- **We cannot guarantee that your insurance will cover any procedure.**
- **You are responsible for your insurance coverage, their practices and any unpaid balance.**

PAYMENT IS EXPECTED IN FULL AT THE TIME OF SERVICE

- Our office files insurance benefits as a courtesy to you.
- All deductibles, copayments, and non-covered fees are due at the time of service.

I understand that Taylor Brook Dental Associates cannot guarantee insurance coverage. I understand that I am responsible for any unpaid balance not covered by insurance. I authorize the release of all information necessary to secure benefits otherwise payable to me. I assign directly to TBDA all insurance payments otherwise payable to me. I understand that I am responsible for the full balance.

Finance charges of 1.5% per month will be charged on all past due accounts. We accept cash, checks, Visa, MasterCard, Discover, and American Express.

_____ Date: _____
Signature of Patient, Parent, or Guardian (Financially Responsible Party)

_____ _____
Printed Name of person signing Patient Name (if different)