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

_____
Email Address

Preferred Communication
☐ Phone ☐ Text ☐ Email

Social Security Number
_____-_____-_____

☐ Male ☐ Female

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 TO A PATIENT SERVICES REPRESENTATIVE

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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):

_____ _____

_____ _____

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. Finance charges of 1.5% per month will be charged on all past due accounts. We accept all major credit cards, checks and cash.

_____ _____
Patient Signature Date