Bangor Center for Dental Medicine

Patient Information Sheet

Please Print

Today's Date: _____

Patient Name: _____

Preferred Name: _____ Date of Birth: _____

Mailing address: _____

_____

Cell phone: _____ Home phone: _____

E-mail address: _____

Employer: _____ Work phone: _____

How would you prefer to be contacted? Cell ☐ Home ☐ Work ☐ E-mail ☐

How did you hear about us? _____

In case of an emergency who should we contact? _____

Relationship:_____ Best daytime telephone number: _____

Who is your Primary Care Physician? _____

In what town?: _____

Name of previous/current dentist:_____

In which town?_____ Date of last visit: _____

Insurance: Yes ☐ No ☐

<u>If you have an insurance card for us to copy, no other insurance information needs to be completed.</u>

If you have insurance and NO card, please tell us:

Name of insurance company:_____

Address of company: _____

Name of primary holder of this insurance:

_____ Date of birth_____

Employer: _____

Insurance ID #: _____ Group #: _____

Is there another insurance? Yes ☐ No ☐ If yes, do you have an insurance card? Yes ☐ No ☐

If no card available, please tell us:

Name of insurance company:_____

Address of company: _____

Name of primary holder of this insurance:

_____ Date of birth_____

Employer: _____

Insurance ID #: _____ Group #: _____