Scott Burke, DMD, FAGD | Leigh Philbrick, DMD, MAGD | Thomas W. Corwin, DDS, FAGD

NEW PATIENT REGISTRATION

Restorative and Aesthetic Dental Associates
650 Brighton Ave. Portland, ME 04102
207.773.6331 | fax 207.773.3701
smile@dentistswholisten.com

SECTION 1

FULL NAME		BIRTHDATE	SOCIAL SECURITY#	
NAME WHICH YOU WOULD LIKE TO BE CALLED	☐ MALE ☐ FEMALE	MARITAL STATUS	REFERRED BY	
ADDRESS		CITY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE	EMAIL	

SECTION 2: Please fill in ALL contact information and check TWO preferred methods for confirming appointments.

EMPLOYER	TITLE/POSITION		CAN WE CALL YOU AT WORK? ☐ YES ☐ NO	
YOUR EMPLOYER'S ADDRESS		CITY	STATE	ZIP
SPOUSE/PARTNER'S NAME	HIS/HER EMPLOYER	BIRTHDATE	SOCIAL SECURITY #	
SPOUSE/PARTNER'S EMPLOYER'S ADDRESS		CITY	STATE	ZIP

SECTION 3: To be completed if patient is under age 18 or a student.

MOTHER'S FULL NAME	DATE OF BIRTH	FATHER'S FULL NAME	DATE OF BIRTH
ADDRESS (if different from section 1)		ADDRESS (if different from section 1)	
MOTHER'S EMPLOYER	SOCIAL SECURITY #	FATHER'S EMPLOYER	SOCIAL SECURITY #

HOME PHONE	CELL PHONE	WORK PHONE	HOME PHONE	CELL PHONE	WORK PHONE

SECTION 4: To be completed for all patients.

RESPONSIBLE PARTY FOR PAYMENT OF SERVICES	RELATIONSHIP TO PATIENT	DO YOU HAVE DENTAL INSURANCE? ☐ YES ☐ NO		
ADDRESS	CITY	STATE	ZIP	PHONE

By signing below, I certify that the above information is correct to my knowledge. I understand that services are payable when rendered unless prior arrangement have been made with the business office. Charges submitted to insurance carriers are done with benefits assigned to this office and the remaining balance payable within 30 days of first statement date. Payment options are Visa, Master Card, Discover, and American Express. Outside financing is available.

Signature _____ Date (DD/MM/YYYY) _____