ANDROSCOGGIN
DENTAL GROUP

Patient Information:

First Name: ________________________ Last Name:_________________________________Middle Initial:___

Preferred Name: ___________________________

Address:______________________________________City:______________________State/Zip________________

Home Phone: ____________________ Work Phone: ______________________ Cell Phone:_________________

I would like to receive email / text for confirming my appointments and specials the practice runs

E-mail:____

Birth date:_______________________ Social Security #:___________________ Drivers Lic#: _______________

Sex: ○ Female ○ Male Marital Status: ○ Married ○ Single ○ Divorced ○ Life Partner ○ Widowed

Responsible Party: (if someone other than the patient)

First Name: _________________________ Last Name: _________________________________

Birth date: _______________________ Social Security #:___________________

Preferred Pharmacy:____

How did you hear about Androscoggin Dental Group?____

DENTAL **Insurance Information:** **_____ (check if) NONE**

Name of Insured:____

Relationship to Insured: ○ Self ○ Spouse ○ Child ○ Other

Carrier ID:____

Insured Social Security #:_____________________________ Insured Birth date:________________________

Employer:____ Insurance Company:______________________

Address:____ Address:_______________________________

Address 2:____ Address 2:______________________________

City, State, Zip:_____________________________________ City, State, Zip:_________________________