Mount Auburn Dental
James F. Helmkamp, DDS, MAGD
207-782-3971

227 Mount Auburn Ave., Auburn
www.mountauburndental.com

Patient Information Form

Name: ________________________________ ________________________________ ___ _______________
Last First MI Date of Birth

Social Security #: ____________________ Email Address: ____

Address: ____ _____________________ ___________ ____________
Mailing address City State Zip

Home Phone: ___________________ Work Phone: ____________________ Cell Phone:____________________

Which is the best way to reach you to confirm appointments? ______________

Which pharmacy do you use and where: ____

Who may we thank for referring you to our practice? ____

We ask that you kindly give us 48 hours if you need to reschedule an appointment. We know your time is valuable and our time is valuable too. We know things come up and sometimes that is not possible in an emergency and we do understand that and would be happy to reschedule you. Giving us a 48 hour window will allow us time to replace your appointment with another waiting to get in. Thank you for doing your best to comply with this request.

Dental Insurance Information

Subscriber Name: ____ Date of Birth: __________________

Subscriber ID #: _____________________________ Group #: __________________

Insurance Company Name: ________________________________ Telephone: __________________

Insurance Company Address: ____

We are happy to submit your dental claims to your insurance and will do everything we can to see that you receive the benefits you are entitled to however, this is YOUR insurance. If your insurance company has not paid on your claim within 45 days, the FULL balance will automatically be transferred to you. You are responsible to seeing that we have your current dental insurance on file. Thank you.

__ I authorize release of any information concerning my/my child's health care recommendations and treatment for the purpose of evaluation and administering claims for insurance benefits.

__ I authorize payment of insurance benefits directly to James F. Helmkamp, DDS, MAGD

__ I understand that my dental insurance benefits may be less than the fee for dental services and may not pay the fee charged in full.

__ I understand that I am responsible for and agree to pay the total fees for my/my child's dental treatment- including my adult children who are on my insurance unless **written** notice is given to this practice stating the adult child is now responsible for the charges he/she incurs PRIOR to any treatment.

__ I agree to pay any applicable deductibles and estimated copayments on the date the dental services are rendered. I understand that not all dental treatment received may be covered by my insurance plan and I agree to pay for any non-covered services on the date the dental services are rendered.

__ I agree to pay the total cost of dental services rendered on the date of service if I/my child does not have dental Insurance benefits.

Patient/Guardian Signature: ___________________________________ Date:________________________________