

Mount Auburn Dental
227 Mount Auburn Ave., Auburn, ME 04210
www.mountauburdental.com
207-782-3971

James F. Helmkamp, DDS, MAGD
Tyler J. Gagnon, DMD

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: _____
(Please check the best phone number to contact you.)

Which pharmacy do you use and where: _____

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 / Tyler J. Gagnon, DMD

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: _____