www.dentistgorhamme.com
405 Main Street, Gorham, ME 04038
(207)839-6266

Andrea M. Taliento, DMD Melissa M. Carrier, DDS

Welcome to our practice! We are genuinely pleased that you have chosen us for your dental care. Our practice realizes the importance of referrals and we value them greatly. We are always excited to see new smiles coming through our door!

At your first appointment, your doctor and hygienist will complete a comprehensive oral examination. This includes a complete review of your medical and dental history, all necessary x-rays and intraoral photos, study models (if necessary), oral cancer screening, periodontal health evaluation and examination of your teeth and soft tissues. Following this exam, your dentist and hygienist will discuss their findings with you, develop a treatment plan that you are comfortable with, and then you will be scheduled according to your needs.

Please be prepared for your appointment by completing the new patient registration forms, bring your photo ID and if you have dental insurance, please be sure to have your insurance card.

We ask that you make every effort to keep your appointments. Missing an appointment disrupts proper sequencing of your care and delays completion of your treatment. If you need to reschedule your appointments, please call us at least 24 hours prior to your visit.

We very much appreciate your confidence in us and look forward to meeting you!

Sincerely,

The Maplewood Dental Arts Team

MAPLEWOOD DENTAL ARTS
providing a lifetime of healthy smiles

Andrea M. Taliento, DMD
Melissa M. Carrier, DDS

PATIENT REGISTRATION FORM

Patient Contact Information

Title ___Patient's name ______________________________ Nickname______________________
Social Security Number: ____________________ Date of birth____________ Sex: Male Female Other
Marital Status: Single Married Divorced Widowed
Street address/PO box ______________________________ City/State____________________
Zip ______________ Email address ____
Home phone ___________ Cell phone ______________ Work ______________ Ext. ______________
I prefer calls at Home Work Cell
Emergency Contact ______________________________ Relation _________ Phone ______________
If full time college student: State _________ Name of School _____________________________
Person responsible for payment of this account ____
Social security number ______________________________________Date of Birth _______________
Street address/PO Box __________________________________ City/State ___________ Zip _______

Patient Employment Information

Employer___________________________ Occupation _______________ Since __________________
Street address/PO Box _______________________________ City/State_______________ Zip _______

Dental Insurance Information

Insurance company name ____
Street address/PO Box _______________________________ City/State _______________ Zip________
Certificate, Group or Policy Number ____
Policyholder Name _______________________________ Relation to Patient ____________________
Policyholder's social security or ID #______________________Policyholder's date of birth _____________
Policyholder's employer/address____
____

I authorize the release of any information necessary to process my claim.

Signature required ______________________________________ Date __________________________

I authorize payment of insurance benefits to the doctor.

Signature required ______________________________________ Date __________________________