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 be prepared to pay at time of service. If you have dental insurance, please bring that information with you as well. Although we do not submit directly to your insurance, we will provide you with the completed paperwork for you to be directly reimbursed.

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 Pronouns: __________________________________
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 # ___________________________________
Policyholder name ____________________________________ Relation to patient ___________________________
Policyholder's Social Security or ID #: _____________________________ Policyholder's Date of Birth ____________
Policyholder's address ____
Policyholder's employer ____

I understand that it is my responsibility to submit my claim information to the insurance company, and I am responsible for the full fee at time of service.

Signature required ____Date______________________