Donald L. Theriault, D.M.D. Office: 207-774-1471 595 Brighton Ave, Portland ME 04102

WELCOME TO OUR OFFICE
PATIENT INFORMATION

Name_____Date_____
How do you wish to be addressed? _____
Residence Address _____
City_____State_____Zip_____
Telephone:
(H)_____(W)_____(Mobile)_____
E-Mail: _____
Social Security #_____Date of Birth_____
Sex: ◯ male ◉ female Marital Status_____
Employed by_____Present Position_____
Who is the party responsible for this account?_____
Address_____
City_____State_____Zip_____
Telephone: (H)_____(W)_____
Whom may we thank for this referral?_____
Your major dental problem or reason for seeking treatment is?_____

DENTAL INSURANCE INFORMATION

Policy holder's name_____S.S.#_____
Policy holder's employer_____
Relationship to policy holder_____
Policy holder's date of birth_____
Name of insurance company_____
Address_____
Telephone #_____
Policy #_____Group #_____

I authorize the release of any medical/dental information to process this claim and authorize direct payment to Dr. Donald Theriault.

_____Signature

WE ARE INTERESTED IN YOU!

Interests, hobbies, sports?_____
Type of music you enjoy?_____
We will try our best to do everything we can to make your time with us as pleasant and comfortable as possible. Any information you might provide to help us do this would be appreciated.