WELCOME TO OUR OFFICE

Initial Exam Date _____

Bright ORTHODONTICS
WE BRIGHTEN SMILES

PATIENT

Patient's Last Name _____ First Name _____ Middle Initial _____

Prefers to be called _____ Hobbies/Activities _____

Birth Date _____ Age _____ Gender: ☐ Male ☐ Female School Grade _____

School/Occupation/Employer _____ Grade/No. Years Employed _____

Home Address _____ City, State, Zip Code _____

Home Phone _____ Patient Cell Phone _____ Patient Email _____

PARENT/GUARDIAN/SPOUSE (if applicable)

Custodial Parent(s) Name(s) _____

Patient lives with (check all that apply) ☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather ☐ Spouse ☐ Other _____

☐ Father / ☐ Stepfather / ☐ Spouse (Full Name) _____

Occupation/Employer _____ No. Years Employed _____ Email _____

Home Address _____ City, State, Zip Code _____

Home Phone (if different) _____ Cell Phone _____ Work Phone _____

☐ Mother / ☐ Stepmother / ☐ Spouse (Full Name) _____

Occupation/Employer _____ No. Years Employed _____ Email _____

Address (if different) _____ City, State, Zip Code _____

Home Phone (if different) _____ Cell Phone _____ Work Phone _____

How did you hear about us? _____

What are your main concerns? _____

_____

Has anyone else in your family been treated by our office? _____ Name of patient(s): _____

Name of your current dentist: _____

Who were you referred by? _____

Have you seen another orthodontist? _____ Name (of orthodontist): _____

OFFICE USE
ID ☐

Bright ORTHODONTICS
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FINANCIAL RESPONSIBILITY - and there is only one responsible party

Who is financially responsible for this account? _____ Birth Date _____
(Our office policy is that the presenting parent is the responsible party)

Address (if different) _____ City, State, Zip Code _____

Home Phone _____ Cell Phone _____ Email _____

Social Security # _____ Employer _____

Who will be responsible for bringing the patient to orthodontic appointments? _____

DENTAL INSURANCE

Primary Policy Holder's Full Name _____ Birth Date _____

Primary Policy Holder's Address _____

Primary Policy Holder's Phone # _____

Insurance Company _____

Insurance Company's Address _____ Phone Number _____

Social Security # or ID # _____ Group # _____ Relationship to Patient _____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

Secondary Policy Holder's Full Name _____ Birth Date _____

Secondary Policy Holder's Address _____

Secondary Policy Holder's Phone # _____

Insurance Company _____

Insurance Company's Address _____ Phone Number _____

Social Security # or ID # _____ Group # _____ Relationship to Patient _____

Does this policy have orthodontic benefits? ☐ Yes ☐ No ☐ Don't Know

I understand that where appropriate, credit bureau reports may be obtained.

I Authorize the dentist to release any information for insurance purposes for payment and agree to be responsible for all charges not covered by my insurance. I also authorize direct payment of insurance benefits to the dentist for services rendered.

Signature (Parent's signature if minor) _____