Welcome

My name is...

____

But, you can call me...

____

I play...
(sport or instrument)

____

____

____

Braces would be...

____

____

____

My friends...

____

____

____
come here for their braces too!

I have a pet.
It's a...

____

____

and I call it...

____

____

My hobbies are...

____

____

____

My favorite music group is...

____

____

My favorite TV show is...

____

and I like to read...

____

____

The greatest thing happened to me and it was...

____

____

I wish I could...

____

____

Our patients become our friends! We are not only here to serve you and provide you with excellent orthodontic care but want you to enjoy your experience with us.
Please help us get to know you by telling us about yourself...
Thanks,

____

DAVID S. BRIGHT
ORTHODONTICS
ORTHODONTICS EXCLUSIVELY

P 281.599.1155 | **F** 281.599.3811 | **W** brightbraces.com
Katy, TX | Richmond, TX

Medical History

PATIENT INFORMATION

Date ______________________________ Patient's Dentist ______________________________

Patient's Name (First, Middle, Last) ______________________________

Address (Street, City, Zip) ______________________________

Home Phone ______________________________ Patient's DOB ______________________________

If patient is a minor, give parent or guardian's name ______________________________

Whom may we thank for referring you to our office? ______________________________

RESPONSIBLE PARTY INFORMATION

Name ______________________________ Marital Status ______________

Address (Street, City, Zip) ______________________________

How long at this address ________ Home Phone ______________ Work Phone ______________

(Cell Phone) ______________________________ E-mail Address ______________________________

SSN ______________________ DOB ________ Relationship to the patient ______________

Employer ______________________________ Occupation ______________ Yrs Employed ______

Spouse"s Name ______________________________ Relationship to Patient ______________

SSN ______________________ DOB ________ Work Phone ______________ Cell ______________

PRIMARY INSURANCE INFORMATION

Insured's Name ______________________________ Insured's SSN ______________

Insurance Company ______________________ Group/Policy # ______________ Phone ______________

Insurance Co. Address (Street, City, State, Zip) ______________________________

Insured's Employer ______________________________ Employer Phone ______________________________

If you are covered for dental by a secondary Insurance Co., please fill our below.

Insured's Name ______________________________ Insured's SSN ______________

Insurance Company ______________________ Group/Policy # ______________ Phone ______________

Insurance Co. Address (Street, City, State, Zip) ______________________________

Insured's Employer ______________________________ Employer Phone ______________________________

EMERGENCY INFORMATION

Name of nearest relative not living with you (First, Middle, Last) ______________________________

Complete Address (Street, City, State, Zip) ______________________________

Are you aware that some appointments will infringe upon work or school time? ______________

Signature (Parent's signature if minor) ______________

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

Continued on back

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MEDICAL HISTORY

Physician ______________________________ Date of last visit ______________________________

Address (Street, City, Zip) ____

Please circle Yes or No (If yes, please fill in details).

Yes No Are you taking any medication? ______________________________

Yes No Are you allergic to any medication? ______________________________

Yes No Do you have a history of a major illness? ______________________________

Yes No Have you had any major operations? ______________________________

Yes No Have you ever been involved in a seriously accident? ______________________________

Circle any of the medical conditions below that you have had or currently have.

Abnormal Bleeding	Epilepsy	Kidney Problems
Anemia	Gastrointestinal Disorders	Nervous Disorders
Arthritis	Heart Murmur	Pneumonia
Asthma or Hay Fever	Heart Problems	Prolonged Bleeding
Bone Disorders	Hepatitis/Liver Problems	Radiation/Chemotherapy
Congenital Heart Defect	Herpes	Rheumatic Fever
Diabetes	High Blood Pressure	Tuberculosis
Dizziness	HIV+/AIDS	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of?

____

DENTAL HISTORY

Dentist ______________________________ Date of last visit ______________________________

Address (Street, City, Zip) ______________________________ Phone ______________

What concerns you most about your teeth? ______________________________

Yes No Are you presently experiencing any dental pain? ______________________________

Yes No Have you ever experienced any unfavorable reaction to dentistry? ______________

Yes No Have you ever lost or chipped any teeth? ______________________________

Yes No Have there been any injuries to face, mouth or teeth? ______________________________

Yes No Is any part of your mouth sensitive to temperature or pressure? ______________

Yes No Do your gums bleed when you brush? ______________________________

Yes No Do you have any type of thumb or tongue habit? ______________________________

Yes No Are you a mouth breather? ______________________________

Yes No Have you ever seen an orthodontist? ______________________________

Yes No Has anyone in the family received orthodontic treatment? ______________

How did they feel about the result? ______________________________

What is your attitude toward receiving orthodontic treatment? ______________

AUTHORIZATION & RELEASE

- I have read and answered the above questions to the best of my knowledge.
- I authorize my insurance company to pay to the orthodontist all insurance benefits otherwise payable to me for services rendered.
- I authorize the use of this signature on all insurance submissions.
- I authorize the orthodontist to release all information necessary to secure the payment of benefits
- I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature ____ Date ______________

Benefits

Benefits of Orthodontics; Aesthetics, Health, and Functions.

Orthodontics is a service that provides an improvement in the appearance and general function of the teeth , as well as providing greater dental health. Teeth, gums, and jaws are intricate body parts and can fail to respond to treatment. If good oral hygiene is not practiced, tooth decay and enlarged gums may result. Joint discomfort and root shortening are observed in a small percentage of cases. Teeth change throughout our lifetime and there can be some movement of teeth and change after treatment.

I have read and understand this paragraph.

Signature_______________________________ Date___________________________

Witness Signature________________________ Date___________________________

Acknowledgment of Receipts of

NOTICE OF PRIVACY Practices

By signing below, I acknowledge that I have received or reviewed the Notice of Privacy. I agree with the terms of this notice and understand my rights under this notice.

By signing below, I consent for the use of my personal health information for the treatment, payment, and operations and other uses as described in the privacy notice.

I also understand that I have the right not to sign the agreement.

Name: ______________________________

Signature: ______________________________

Relationship to Patient: ______________________________

Date: ______________________________

If we are unable to get acknowledgment, then our office will make a notation as to the reason why it was not obtained.

Reason the acknowledgment was not obtained:

____

____

____

Staff Member Name: ______________________________

Signature: ______________________________

Date: ______________________________

DAVID S. BRIGHT ORTHODONTICS

ORTHODONTICS EXCLUSIVELY

I, __________________________ understand that my Insurance Carrier will be billed for a total evaluation and xrays for today's visit. My portion is complimentary.

Patients Name: ________________________________

Signature: ____________________________________

Date: ____

BRIGHT ORTHODONTICS
ORTHODONTICS EXCLUSIVELY

HOW DID YOU HEAR ABOUT US?!

We would like to personally thank them for referring you to our office!

______ Insurance	______ Website
______ Dentist	______ Internet Search
______ Patient	______ Welcoming Neighbor
______ Word Of Mouth	______ Sign
______ Yellow Pages	______ Other
______ Staff Member	

*Please list name/source: ______

New Patient Name: ______

Date: ______

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