WELCOME

Thank you for choosing Bright Dental Studio! Our goal is to provide you with the best possible dental care. To help us reach that goal, please fill out these forms completely with an ink pen. If you have any questions or need assistance, please ask and we will gladly help you complete your forms.

PERSONAL INFORMATION

Name:_____(wish to be called)_____

☐Male ☐Female ☐Other-please explain_____

Birthdate:_____ SSN#_____ Driver's License #_____

Address:_____

City: _____ State: _____ Zip code:_____

Employer:_____Occupation:_____

Email address:_____

Home #:_____ Cell #:_____ Work #:_____

Referred by:_____

RESPONSIBLE PARTY (Who is the head of household for this account?)

Name:_____ Relationship to patient_____

Birthdate:_____ SSN#_____ Driver's License #_____

Address:_____

City: _____ State: _____ Zip code:_____

Employer:_____Occupation:_____

Email address:_____

Home #:_____ Cell #:_____ Work #:_____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name:_____ Relationship to patient_____

Home #:_____ Cell #:_____ Work #:_____

DENTAL INSURANCE INFORMATION

PRIMARY INSURANCE

Name of Insured_____

Relationship to patient_____

Insured's Birthdate_____

Employer_____

Insurance Company_____

Policy/ID#_____

Group #_____

Address of Ins. Co._____

Phone # of Ins. Co._____

SECONDARY INSURANCE

Name of Insured_____

Relationship to patient_____

Insured's Birthdate_____

Employer_____

Insurance Company_____

Policy/ID#_____

Group # _____

Address of Ins. Co._____

Phone # of Ins. Co._____

AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payors and/or other health care practitioners.

I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me.

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X_____

Signature of patient or parent/guardian of patient Date

FINANCIAL ARRANGEMENTS

PAYMENT IN FULL AT EACH APPOINTMENT

For your convenience, we offer the following methods of payment:

_____Cash/Check

_____Credit Card (Visa, MC, Discover, AmEx)

_____I wish to discuss/explore other financial options available

If you do not pay the entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month (if allowed by law). I realize that failure to keep this account current may result in my family or myself being unable to receive additional dental services except for dental emergencies or where there is prepayment for additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees incurred in attempting to collect on this amount of any future outstanding account balances.

Thank you for filling out this form completely.

The information you have provided will help us serve your dental healthcare needs more effectively and efficiently. If you have any questions, please ask – we are always happy to help.