Bedford Orthodontics

Orthodontics for children and adults

Patient ID#: _____

Welcome to Bedford Orthodontics! Please assist us in answering the following (complete in ink):

Patient Information

Patientôs Name: _____ Nickname: _____
Date of Birth: _____ Age: _____ Gender: M / F
Address: _____ City: _____ State: _____Zip: _____
Home Phone: _____ Cell: _____ Work: _____
If patient is a minor, give parent or guardian names: _____
Who may we thank for referring you to our office? _____
Family Dentist: _____Physician:_____

If Under 18

School: _____City: _____Grade: _____
Hobbies: _____Siblings (ages):_____
Has any family member had braces before? If so, who? _____

Responsible Party

First Name: _____ M.I.____ Last Name: _____ Marital Status_____
Address: _____ City: _____ State: _____ Zip: _____
Email Address: _____ SSN#:_____-_____-_____
Home Phone: _____Cell:_____Work:_____
Relation to Patient: _____Spouseôs Name: _____

Insurance Information

Full Name of Subscriber: _____ Subscriber Birth Date: _____
SSN or ID #:_____ Relation to Patient: _____
Employer: _____ Occupation:_____
Insurance Company: _____ Group Number: _____
Insurance Company Address: _____
Insurance Company Phone: _____

Please inform the Front Desk if you have additional dental insurance

Release

I assign all insurance benefits otherwise payable to me to Bedford Orthodontics. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Responsible Party:_____ **Date: _____**

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