

RICHARD M. BACH, D.D.S.
BACHORTHODONTICS.COM

Date _____

Patient _____
Last First Initial Birth Date _____

Marital Status S M W D SEP Spouse's Name _____

Home Phone _____ Cell # _____

Social Security Number _____ Home Email Address: _____

Home Address _____
Street Town Zip Code

Person Responsible For Bill? _____

Billing Address _____
Street Town Zip Code

Employer's Name _____ Occupation _____

Employer's Address _____ Business Telephone _____

Dentist _____ Physician _____

Who referred you to us? _____

Reason for visit? _____

Do you have any history of the following?

- | | |
|---------------------------------|---|
| _____ Allergies | _____ Operations in last 10 years |
| _____ Heart Disorders | _____ Blood Transfusions in last 10 years |
| _____ Blood Disorders | _____ X-Ray in past 5 years |
| _____ Circulatory Problems | _____ History of Immune Deficiencies |
| _____ Neurological Disorders | _____ Needed Periodontal Treatment |
| _____ Radiation Treatment | _____ Clenching or Grinding Teeth |
| _____ Liver or Kidney Disorders | _____ Joint Problems of the Jaw |
| _____ Endocrine Disorders | _____ Accident to Teeth or Jaw |
| _____ Pulmonary Problems | _____ Presently Pregnant |
| _____ Sleep Apnea | _____ Past Orthodontic Treatment |

Comments: _____

Signature to allow us to request needed X-rays or records
from other offices

Signature to allow use of records in lectures and seminars by Dr. Bach

If You Have ORTHODONTIC INSURANCE Please Complete the Back of This Form

PRIMARY INSURANCE INFORMATION

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone () _____
Employer's Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local _____
Address _____ City _____ State _____ Zip _____

DO YOU HAVE ANY ADDITIONAL INSURANCE _____ YES _____ NO. If, yes complete the following:

SECONDARY INSURANCE INFORMATION:

Name of Insured _____ Relationship to Patient _____
Birthdate _____ Social Security # _____ Date Employed _____
Employer _____ Work Phone () _____
Employer's Address _____ City _____ State _____ Zip _____
Insurance Company _____ Group # _____ Union or Local _____
Address _____ City _____ State _____ Zip _____

AUTHORIZATION AND RELEASE

To the best of my knowledge, the above information is complete and correct. I understand that it is My responsibility to inform my doctor if I, or my minor child, ever have a change in health.

And assign directly to Dr. Bach all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above named-named dentist may use my health care information and may disclose such information to the above-named insurance Company(ies) and their agents for the purpose of obtaining payment for Services and determining insurance benefits or the benefits payable for related services.

Signature of Patient

Date