

# BACHORTHODONTICS.COM

Patient \_\_\_\_\_ Date \_\_\_\_\_  
Last First Initial

Birth Date \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Mother \_\_\_\_\_ Father \_\_\_\_\_ Parent's marital status S M W D SEP

Mother's Home Address \_\_\_\_\_  
Street Town Zip Code

Father's Home Address \_\_\_\_\_  
Street Town Zip Code

Person Responsible For Bill \_\_\_\_\_

Billing Address \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Home E-Mail Address \_\_\_\_\_

Father Employed \_\_\_\_\_ Bus. Telephone \_\_\_\_\_ Cell # \_\_\_\_\_

Employer's Address \_\_\_\_\_

Father's Occupation \_\_\_\_\_

Mother Employed \_\_\_\_\_ Bus. Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

Employer's Address \_\_\_\_\_

Mother's Occupation \_\_\_\_\_

Patient's Dentist \_\_\_\_\_ Who referred you to us? \_\_\_\_\_

Patient's Physician or Pediatrician \_\_\_\_\_

Reason for Consultation \_\_\_\_\_

Who to contact in an emergency? \_\_\_\_\_

(other than parent) Name Relationship Phone #

Please circle if patient has a history of the following problems:

Heart Valve	Y	N	Thumb Sucking	Y	N
Circulation/Bleeding	Y	N	Allergies	Y	N
Kidney/Liver	Y	N	Breathing, Sleep Problems	Y	N
Nervous System	Y	N	Tonsils/Adenoids	Y	N
Learning/Education	Y	N	Speech	Y	N
Hereditary Medical	Y	N	Hereditary Dental	Y	N

Explanation of other significant information OR adverse past experiences in a Doctor or Dentist's office

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature to allow us to request needed X-rays  
(includes digital)  
or records from other offices.

Signature of parent or legal guardian attesting to information

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 ORTHODONTIC INSURANCE INFORMATION**

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Insured's 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 ORTHODONTIC INSURANCE INFORMATION:**

Name of Insured \_\_\_\_\_ Relationship to Patient \_\_\_\_\_  
Insured's 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.

I certify that I, and/or my dependent(s), have insurance coverage with \_\_\_\_\_  
Name of Insurance Company (ies)

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 us of my signature on all insurance submissions.

The above named-named dentist may us my health care information and my 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, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print name of Patient, Parent, Guardian or Personal Representative

\_\_\_\_\_  
Relationship to Patient