Bay Tree ORTHODONTICS

Thank you for choosing Bay Tree Orthodontics for your braces! We're very excited to begin treatment, but before we do, we need to get some information. Please fill out the fields below to the best of your ability. You may then print a copy to bring in with you or save a copy (with the patient's name in the file name) and email it back to us.

We don't need a picture of you just yet, but if you would like to send us one, you welcome to. Just attach the file to the email with a copy of this form or send the photo to info@baytreebraces.com.

We can't wait to see you soon!

The Bay Tree Orthodontics Team
www.baytreebraces.com

Patient Information

Name:_____
Birthday:_____
Social Security Number:_____
Home Phone Number: _____
Mobile Phone Number:_____
Email:_____
Address (if different than above): _____
City:_____State:____ ZIP Code:_____
Dentist: _____ Physician:_____

How may we contact the patient?
- ☐ Phone message
- ☐ SMS text message
- ☐ Email

Responsible Party Information (if different from above)

Name:_____
Do you have any other family members being treated at our practice? Yes No
If Yes, what are their names? _____
Birthday:_____
Home Phone Number: _____
Mobile Phone Number:_____
Email:_____
Address (if different than above): _____
City:_____State:____ ZIP Code:_____
Is the above party the primary person who brings the patient to appointments? Yes ◯ No ◯
If No, who will be bringing the patient to appointments? _____
What is their relationship to the patient? _____

How may we contact you?
- ☐ Phone message
- ☐ SMS text message
- ☐ Email

Additional Responsible Party Information

Name:_____
Birthday:_____
Home Phone Number: _____
Mobile Phone Number:_____
Email:_____
Address (if different than above): _____
City:_____State:____ ZIP Code:_____

How may we contact them?
- ☐ Phone message
- ☐ SMS text message
- ☐ Email

Billing Information

Which of the above parties is responsible for payment?_____

Who is the primary responsible party's employer? _____
What is their Social Security Number (if required)?_____
What is their work address? _____
What is their work email address? _____
What is their work phone number? _____

Who is the secondary responsible party's employer? _____
What is their Social Security Number (if required)?_____
What is their work address? _____
What is their work email address? _____
What is their work phone number? _____

If paying by credit (may be completed later):
What type of credit card will be used?: _____ _____
What is the card number?: _____
What is the expiration date?_____

If paying by bank draft (may be completed later):
What bank do you use?:_____
What is the routing number on the account?:_____
What is the account number?_____

If you have insurance that includes orthodontic coverage:
What company is it with? _____
What the group number? _____
What the policy number? _____

- ☐ I authorize the use of this form on all my insurance submissions
- ☐ I authorize release of my insurance information to all my insurance carriers
- ☐ I understand that I am responsible for all charges not covered by insurance
- ☐ I authorize my doctor to act as my agent in helping me obtain payment from my insurance carrier
- ☐ I authorize payment directly to my doctor
- ☐ I permit a copy of this authorization to be used in place of the original

Signature:_____ Date: _____

Responsibility and Consent

I hereby authorize and request the performance of orthodontic services for myself or for:

Name:_____ Age: _____

I also give my consent to any advisable and necessary orthodontic procedures to be administered by the attending orthodontist or by the supervised staff for diagnostic purposes or treatment.

I understand and acknowledge that I am financially responsible for payment in full of all services provided to myself or the abovenamed party, regardless of insurance coverage.

Signed:_____ Date:_____
Name: _____ Relationship to above party: _____