


BE Orthodontics
Bailey-Bruster & Ellis Orthodontics



Patient's Name _____ Birthdate _____
General Dentist _____ Last Cleaning _____

Account Information/Person Responsible for Bill

Mr./Mrs./Ms. _____ Birthdate: _____

Address: _____
Last First MI

Home Phone: _____

Street _____

Cell Phone: _____

City _____ Zip _____

SS# _____

Employer _____

Work Phone: _____

How long been employed there? _____

Position _____

Name of Spouse or second parent or guardian

Mr./Mrs./Ms. _____ Birthdate: _____

Address: _____
Last First MI

Home Phone: _____

Street _____

Cell Phone: _____

City _____ Zip _____

SS# _____

Employer _____

Work Phone: _____

How long been employed there? _____

Position _____

Additional family members or dependents who may become our patients:

Name	Relationship	Birthdate
_____	_____	_____
_____	_____	_____

Emergency Contact (friend or relative not living with you)

Name _____

Home Phone _____

Relationship _____

Work Phone _____

We appreciate the confidence our patients have in us and would like to know whom we may thank for referring you to our office.

Your dentist _____

A patient _____

A friend _____

Other _____

Financial Information

If you have dental insurance, please provide the following information:

Insurance Co. Name: _____ Phone Number: _____

Insurance Co. Claim Mailing Address: _____

Policy Holder Name: _____ Policy Holder SS #: _____

Member ID#: _____ Group #: _____

Dental Insurance Release

Please Note:

To better serve the needs of our patients when expediting insurance claim forms, we request your signature after reading the authorization below.

Authorization to pay Benefits to Orthodontist(s)

I hereby authorize payments directly to the orthodontist(s) of the insurance benefit otherwise payable to me for their services.

Signature on File _____

Information release

I hereby have reviewed the treatment plan and authorize the release of any information relating to my treatment or pre-authorization including x-rays and study models.

Signature on File _____

BE Orthodontics, Inc., Office Guidelines

Thank you for taking the time to fill out these patient information forms. The following guidelines are intended to help meet the needs of all of our patients.

When you make an appointment, that time and procedure is carefully planned to meet your individual needs. Please do not reschedule your appointment unless it is absolutely necessary, for it is often difficult to schedule someone else in a time that was reserved for you. If you are not able to keep an appointment, please give us as much notice as possible. If less than 48 hours is given, we reserve the right to charge you for that missed appointment time.

We are always happy to answer any questions you may have. You should be kept informed as to what treatment is needed and what it will cost. **(All fees are due at the time treatment is performed unless other arrangements have been approved in advance.)** A \$25 late fee will be added to the account for payments not made within **30 days** of the due date.

For your convenience, we will gladly file dental insurance claims. We will allow you to assign payment to our office so that you will not have to wait for the payments, provided we receive the following from you:

- 1) Copy of your insurance card and driver's license (will need with or without insurance).
- 2) Signatures on the insurance forms that assign benefits to our office (a signature will be required annually).

It is our office policy to bill your insurance carrier as a courtesy to you, although YOU are responsible for the entire balance. Once the carrier is billed, we will set aside that portion of the balance estimated to be paid by your insurance carrier for 60 days. **If your carrier does not remit payment within 60 days, the balance will be due from you. When the insurance payment is received we will refund the credit amount to you.**

The undersigned has read and understands the above and hereby authorizes the orthodontist(s) to perform any procedure that is deemed necessary in the best interest of the patient's health.

Signature _____ Date _____

Witness _____ Date _____