WELCOME!

So that we may provide you with the best possible care, please complete this form and the health and dental history form.

All Information is completely confidential.

BravoSmile

Timothy S. Chapman, D.M.D.
2075 SW First Ave., Suite 2k
Portland, OR 97201
Phone: 503.222.3591
Fax: 503.222.4496

1. ABOUT YOU

Today's Date _____

Name _____

Name I'd like to be called _____ M ☐ F ☐

Birthdate _____ Age _____ SS # _____

Home Address _____ Apt # _____

City _____ State _____ Zip _____

Single ☐ Married ☐ ☐ MR ☐ MRS ☐ DR ☐ REV

Home Phone (___) _____ Work Phone (___) _____ Ext _____

Pager (___) _____ Cell (___) _____

E-mail _____

Driver's license number _____

Employer _____

Employer's Address _____

Present Position _____ How long held _____

Other family members seen by us _____

When and where are best times to reach you? _____

Who may we thank for referring you? _____

2. BILLING INFORMATION

Person responsible for this account? _____

Billing Address _____ Apt # _____

City _____ State _____ Zip _____

Home Phone (___) _____ Work Phone (___) _____ Ext _____

Driver's license number _____

Employer _____

Relationship to patient _____

Method of payment will be:

Cash ☐ Check ☐ Credit/Debit Card ☐ Insurance ☐ Other ☐

3. SPOUSE INFORMATION

His/Her Name _____

Home Phone (___) _____ Work Phone (___) _____ Ext _____

Birthdate _____ Social Security No: _____

Driver's license number _____

Employer _____

Nearest neighbor or relative not living with you:

His/her Name _____ Relation _____

Address _____ Apt # _____

City _____ State _____ Zip _____

Home Phone (___) _____ Work Phone (___) _____ Ext _____

4. INSURANCE

Bold items are required information in order for us to accurately submit your dental claims. FAILURE TO COMPLETE ALL ITEMS IN BOLD WILL DELAY YOUR BENEFITS!!

Primary Insurance

Dental Coverage Yes ☐ No ☐

POLICY OWNER'S NAME _____

POLICY OWNER'S SS # _____

POLICY OWNER'S BIRTHDATE _____

RELATION _____

INSURANCE COMPANY NAME _____

INSURANCE COMPANY ADDRESS _____

City _____ State _____ Zip _____

INSURANCE COMPANY PHONE # (____) _____

UNION OR LOCAL GROUP # _____

Program or policy # _____

EMPLOYER _____ Contact _____

Employer address _____

City _____ State _____ Zip _____

Secondary Insurance

Dental Coverage Yes ☐ No ☐

POLICY OWNER'S NAME _____

POLICY OWNER'S SS # _____

POLICY OWNER'S BIRTHDATE _____

RELATION _____

INSURANCE COMPANY NAME _____

INSURANCE COMPANY ADDRESS _____

City _____ State _____ Zip _____

Union local or group number _____

PROGRAM OR POLICY NUMBER _____

EMPLOYER _____

Employer's address _____

AUTHORIZATION AND RELEASE

If you have dental insurance, we will prepare and submit your dental Claims as a courtesy to you.

I acknowledge that I am financially responsible for all charges whether or not they are covered by insurance. I hereby authorize payment directly to Bravo Smiles of the group insurance benefits otherwise payable to me. I also authorize release of any information including the diagnosis and records of treatment or examination rendered to my insurance company. If it becomes necessary to effect collections of any amount owed on this, or subsequent visits, the undersigned agrees to pay for all costs and expenses including reasonable attorney fees.

_____

Signature (Responsible Party) Date

REORDER #01-1935