BRIGHTSIDE
family dental
Anita Maddali, DMD

Date: ____/____/_____

Name: _____
LAST FIRST MI

Preferred Name? _____ **Male / Female**

Address: _____

_____
City State Zip

Home Phone: (___)_____
Work Phone: (___)_____
Cell Phone: (___)_____
Email: _____
Best Time & Place to Reach You? _____
Referred By: _____

Status: Minor / Single / Married / Divorced / Separated / Widowed
Spouse's Name: _____

Do you have children? Y / N How Many? _____

Date of Birth ___/___/_____ **Age:** _____
SSN: _____ **Driver's Lic. #** _____

Employer: _____
Address: _____
_____
Occupation: _____

Primary Insurance:

Company Name: _____
Co Address: _____
_____
City State Zip
Co Phone #: (___)_____
Group # : _____
Insured's Name: _____
Insured's ID #: _____
Relation: _____ **DOB:** ___/___/____
Insured's Employer: _____

Secondary Insurance:

Company Name: _____
Co Address: _____
_____
City State Zip
Co Phone #: (___)_____
Group # : _____
Insured's Name: _____
Insured's ID #: _____
Relation: _____ **DOB:** ___/___/____
Insured's Employer: _____

Person Ultimately Responsible For Account:

Name: _____
Relation: _____
Billing Address: _____
_____
City State Zip
SSN: _____
Work Phone # (___)_____
Payment Method: Cash / Check / Credit Card

_____ ___/___
Credit Card Number above

** I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company.**

Please initial here: ☐

In the Event of an Emergency:

Whom Should We Contact?

Name: _____
Relation: _____

Home Phone: (___)_____
Work Phone: (___)_____
Cell Phone: (___)_____

Who is your Medical Doctor?

Name: _____
Doctor's Phone #: (___)_____

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