

**Welcome to Bristol Dental and Orthodontics**  
**2502 S. Bristol St.**  
**Santa Ana, CA 926704**

**1**

**Patient**

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Phone: \_\_\_\_\_ Cell: \_\_\_\_\_  
Last First

Address: \_\_\_\_\_ Apt: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

How long in this address: \_\_\_\_\_ Email: \_\_\_\_\_

Social Security #: \_\_\_\_\_ DL #: \_\_\_\_\_ Age: \_\_\_\_\_ Birth date: \_\_\_\_\_

**2**

**Getting to Know You**

Are there other members of your household who are not patients at our office? Yes No

Please list names & Relationship (son, daughter, husband) below:

1. \_\_\_\_\_ 2. \_\_\_\_\_  
3. \_\_\_\_\_ 4. \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

Are you or anyone else in your family a Union Member? Yes No

If Yes, specify Union / Local: \_\_\_\_\_

I want information in Spanish Yes No

**3**

**Employment**

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

How Long: \_\_\_\_\_ Phone: \_\_\_\_\_ Ext: \_\_\_\_\_

Business Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Verified By: \_\_\_\_\_ Date: \_\_\_\_\_

1. I hereby certify that information I have given is accurate and will be relied upon for granting credit and providing dental service. I understand that I am financially responsible for the charges not covered by or paid for by my insurance for whatever reason.
2. By signing below, I understand that you may verify and exchange information on me and any additional applicants, including requiring reports from credit reporting agencies.
3. I hereby authorize payment directly to the dentist of the group insurance benefits otherwise payable to me. I understand that I am financially responsible for any charges not covered by this authorization. I authorize release of any information relating to any dental claim or claims.
4. I understand that Bristol Dental and Orthodontics provides business support services to independent dentist and recognize that this dental practice is operated by an independent dentist. I acknowledge that each dentist is individually responsible for the dental care provided to me and no other dentist nor Bristol Dental and Orthodontics is responsible for my dental treatment.

\_\_\_\_\_  
Signature of responsible party or patient  
(Parent if patient is a minor)

\_\_\_\_\_  
Date