DATE ____________

BRONSKY ORTHODONTICS

Our major goal at Bronsky Orthodontics is to provide the highest quality orthodontic care to you and your family. the experience of being a Board Certified orthodontist has taught me that family health care begins with your first telephone call to our office and continues for a lifetime. We offer a team of a highly trained doctor and staff in a pleasant and friendly environment.

ADULT ORTHODONTIC PATIENT INFORMATION

PATIENT NAME ______________________________
BIRTHDATE ____/____/____ SEX M F PATIENT PHONE #__________________
PATIENT ADDRESS ______________________________
____
OCCUPATION ______________________________
EMPLOYER ______________________________ PHONE # ____________________
EMPLOYER ADDRESS ______________________________

SPOUSE'S NAME ______________________________
BIRTHDATE ___/___/___ SEX M F SPOUSE'S PHONE # ________________
SPOUSE'S ADDRESS ______________________________
____
OCCUPATION ______________________________
EMPLOYER ______________________________ PHONE # ____________________
EMPLOYER ADDRESS ______________________________

FINANCIALLY RESPONSIBLE PARTY NAME ______________________________
RELATIONSHIP ______________ ADDRESS ______________________________
FAMILY DENTIST ______________ ADDRESS/PHONE ______________________________
FAMILY PHYSICIAN ______________ ADDRESS/PHONE ______________________________

FAMILY/MARITAL STATUS Single Married Separated Divorced
Children living at home:
NAME ______________ DOB ___/___/___ NAME ______________ DOB ___/___/___
NAME ______________ DOB ___/___/___ NAME ______________ DOB ___/___/___

I/WE WILL BE FINANCIALLY RESPONSIBLE FOR ALL CHARGES INCURRED FOR THE ABOVE NAMED PATIENT:

______________________________ ______________________________ ________________
Print Full Name **Signature (in ink)** **Date**

______________________________ ______________________________ ________________
Print Full Name **Signature (in ink)** **Date**

WE WOULD LIKE TO THANK THOSE PEOPLE WHO REFER PATIENTS TO OUR OFFICE AND WOULD APPRECIATE YOUR COMPLETING THE FOLLOWING QUESTIONS:

1. Has any member of your family been treated by:

   ________ Dr. Peter Bronsky ________ Other

   ________ None of the above

2. Did a family member recommend Dr. Bronsky?

   ________ Yes, the family member's:
   Name ________________________________
   Address ________________________________
   ____

3. Did a friend recommend Dr. Bronsky?

   ________ Yes, the friend's:
   Name ________________________________
   Address ________________________________
   ____

4. Has that friend or family member been treated by?

   ________ Dr. Peter Bronsky ________ Other

   ________ None of the above

5. Did your family dentist or physician recommend Dr. Bronsky?

   Referring Dentist ________________________ Phone #: ______________

   Referring Physician ________________________ Phone #: ______________

   Referring Hygienist or Assistant (circle) ________________________________

6. If you were not referred to us by a physician, dentist or a relative, how did you select Bronsky Orthodontics, P.C.?

   ____

   ____

Thank you very much for your time and assistance.