Appointment Request Form

BSC Clinic & Dental

320-200-2300
Fax: 320-207-1216
info@brightsmilesclinic.org
www.brightsmilesclinic.org

Patient Information

Name _____

Date Of Birth _____ Gender ◯ Male ◯ Female ◯ Other

Phone Number _____

Address _____

_____

Appointment Details

Preferred Days _____ Alternate Date _____

Preferred Time _____ Alternate Time _____

Reason for Appointment

- ◯ New Patient (Exams/Cleaning)
- ◯ Preventive/ school-based referrals
- ◯ Routine Check-up
- ◯ Specialist Consultation (Dentures, Crowns, Root Canal Therapy)
- ◯ Tooth Pain/ Emergency visits
- ◯ Other: _____

Preferred Language

- ◯ Spanish
- ◯ Somali
- ◯ Arabic
- ◯ Other: _____

Insurance Type

- Name: _____
- PMI # _____

How to Send This Form

✉️ Email: info@brightsmilesclinic.org

📠 Fax: 320-207-1216

📱 Text a photo of this form: (320) 200-2300

📞 Call directly to schedule: (320) 200-2300

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