PATIENT INFORMATION

Last Name____________________First Name____________________Middle Initial______

Preferred Name________________Birthdate____/____/____ Social Security Number________________

Home Phone____________________Cell Phone____________________

Address________________City____________State_____Zip________E-Mail____________

Check Appropriate Box: ☐Minor ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated

Patient's Or Parent/Guardian's Employer____________________Work Phone________________

Business Address________________City____________State________Zip________

Spouse or Parent/Guardian's Name____________________________Birthdate____/____/____

Employer________________________Work Phone____________________

If Patient Is A Student, Name Of School/College____________________City/State____________

Whom May We Thank For Referring You?________________________________

Person To Contact In Case Of An Emergency____________________Phone________________

RESPONSIBLE PARTY

Name Of Person Responsible For This Account____________________Relationship To Patient________

Address____________________Home Phone____________Cell Phone____________

Employer____________________Work Phone____________________

Is This Person Currently A Patient In Our Office? ☐Yes ☐No

INSURANCE INFORMATION

Name Of Insured________________________Relationship To Patient________________

Birthdate____/____/____ Social Security Number________________How Long Employed________

Employer________________________Work Phone ____________________

Insurance Company____________________Group#________Union Or Local#________

AUTHORIZATION FOR SUBMISSION OF CLAIMS & ASSIGNMENT OF BENEFITS

I authorize the office of Orchard Park Family Dentistry to submit claims for payment for services to my dental insurance company on my behalf and in my name, and assign to such provider the group insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for the covered services. I understand that I am financially responsible for any charges not covered by the group insurance benefits.

Signature of Patient, Parent or Guardian____________________________**Date**____/____/____