PATIENT INFORMATION

☐ New Patient … or … ☐ Updating My Info

Last Name _____ First Name _____ Middle Initial _____

Preferred Name _____ Birthdate ___/___/___ Social Security # _____

Home Landline _____ Cell Phone _____

Address _____ E-Mail _____

City _____ State _____ Zip _____ 2nd E-Mail _____

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

Check Appropriate Box: ☐ Male ☐ Female ☐ Other-Preferred pronoun: _____

Patient's Employer _____ Work Phone _____

Employer's Address _____ City _____ State _____

Spouse (or Guardian's) Name _____ Birthdate ___/___/___

Employer _____ Work Phone _____

If Patient is a Student, Name of School/College _____

Whom May We Thank for Referring You? Phone Book, Internet, Other _____

Who Was Your Previous Dental Provider? _____

Person to Contact in Case of Emergency _____ Phone _____

RESPONSIBLE PARTY

Name of Person Responsible for This Account _____

Address _____ E-Mail _____

City _____ State _____ Zip _____ 2nd E-Mail _____

Relationship to Patient _____ Home Landline _____ Cell _____

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 # _____

What is the Name of Your Insurance Carrier? _____

Is This a Plan that Your Employer is Providing to You? ☐ Yes ☐ No

If yes, what is the Name of Your Employer? _____

AUTHORIZATION FOR CLAIMS SUBMISSION & ASSIGNEMENT OF BENEFITS

I authorize the office of Orchard Park Family Dentistry to submit claims for payment of 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 ___/___/___