

## PATIENT INFORMATION

New Patient ... or ...  Updating My Info

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_  
Preferred Name \_\_\_\_\_ Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security # \_\_\_\_\_  
Home Landline \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Mailing 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 & ASSIGNMENT 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 \_\_\_\_ / \_\_\_\_ / \_\_\_\_