Rebecca Falsafi, D.D.S., M.S.
Orthodontics and Orthopedics for Children and Adults

6161 Transit Road
Suite 10
East Amherst, New York 14051
(716) 631-2166
www.falsafiortho.com

Welcome to our practice! Please fill out this form as completely as possible. Please be sure all information is provided, as we cannot process your insurance claim without this information. We also require a copy of your insurance card on file, so please bring it to the consultation appointment with you. It is your responsibility to provide this information completely and accurately so we can properly file and receive your insurance benefits. Thank you.

PATIENT INSURANCE INFORMATION

Patient Name _____ **Birth Date**_____
Home Address_____
Home #_____ **Work #**_____ **Cell #**_____

RESPONSIBLE PARTY (Insured Party)
Responsible Party Name:_____ **Birth Date**___/___/____
Relationship to Patient_____ **SS#**_____-____-_____
Billing Address_____
Home#:(___)_____ **Work #:** (___)_____ **Cell#:**(___)_____
Employer Name_____
Address_____
Insurance Co: _____ **Insurance Co Phone#:**(____)_____
Insurance Co Address:_____
Group #_____ **Policy #**_____

IF SECONDARY INSURANCE EXISTS:

RESPONSIBLE PARTY (Insured Party)
Responsible Party Name:_____ **Birth Date**___/___/____
Relationship to Patient_____ **SS#**_____-____-_____
Billing Address_____
Home#:(___)_____ **Work #:** (___)_____ **Cell#:**(___)_____
Employer Name_____
Address_____
Insurance Co: _____ **Insurance Co Phone#:**(____)_____
Insurance Co Address:_____
Group #_____ **Policy #**_____

This office accepts insurance, however I understand I am responsible for payment of services rendered, as well as responsible for paying any co-payments and deductibles my insurance will not cover. I hereby authorize payment of the group insurance benefits which would otherwise be payable directly to me, payable directly to this office.

_____ **Relationship:**_____ **Date:**___/___/___

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