

Patient Information



Please Fill out this form as completely as you can.

Personal

First Name: _____ Last Name: _____ MI: _____ Preferred: _____
Birthday: _____ SS#: _____ Gender: M F Status: Single Married Child
Home Ph: _____ Wireless Ph: _____ Email: _____
Preferred contact method Home Ph Wireless Ph Text Email
Preferred contact method for confirmations Home Ph Wireless Ph Text Email
Preferred contact method for recall Home Ph Wireless Ph Text Email
Student Status if dependent over 19 (for ins) Full time Part time Non student
How did you hear about us? (Google, Facebook, Instagram, ad, Etc.) _____

(If someone kindly recommended you here, please write down their name so we can thank them!)

Address

Check box if same for the entire family

Address: _____
Address 2: _____
City: _____ State: _____ Zip Code: _____

Insurance Policy

Your relationship to the subscriber Self Spouse Child
Subscriber Name: _____ Subscriber ID#: _____
Insurance Company: _____ Insurance Phone: _____
Employer: _____ Group Name: _____ Group#: _____
Please present insurance card to receptionist.

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Assignment & Release

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Today's Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature: _____
Relationship: _____ Date: _____

CONSENT: I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care.

Patient/Guardian Signature: _____