Welcome to Staten Island Smile - Tell Us About Yourself

Name:_____
Last First MI Title

Preferred Name: _____ □ Male □ Female

Address:_____City _____State_____ Zip _____

SSN:_____ DOB:_____

Home Phone:_____ Work Phone:_____

Cell Phone:_____ E-mail Address:_____

Employer:_____ Occupation:_____

Marital Status: □ Single □Married □Divorced □Widowed □Separated □Domestic Partner

How did you hear about our office?_____

Do you prefer to be contacted for appointment confirmation via e-mail or phone? _____(Please circle preference)

■ Insurance - Primary ■

Subscriber Name:_____Relationship to Patient:_____Subscriber DOB:_____

Subscriber SSN/ID: _____ Subscriber Employer: _____

Insurance Company Name:_____

Insurance Company Address: _____

Insurance Company Phone: _____ Group Number: _____

■ Insurance - Secondary ■

Subscriber Name: _____Relationship to Patient:_____Subscriber DOB:_____

Subscriber SSN III):_____Subscriber Employer:_____

Insurance Company Name:_____

Insurance Company Address: _____

Insurance Company Phone:_____Group Number:_____

■ Assignment and 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: _____