

**CONFIDENTIAL INFORMATION QUESTIONNAIRE**

PATIENT'S LEGAL NAME		LAST,	FIRST	MI	DATE OF BIRTH	SEX	SOCIAL SECURITY #
PREFER TO BE CALLED			HOME PHONE #			CELL PHONE #	
PATIENT'S ADDRESS		STREET	APT#	CITY	STATE	ZIP	E-MAIL
<b>MARITAL STATUS</b>		PATIENT'S / GUARDIAN'S EMPLOYER				OCCUPATION	
<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> UNDER AGE 18							
WORK ADDRESS		STREET	APT#	CITY	STATE	ZIP	WORK PHONE #
SPOUSE'S NAME		LAST,	FIRST	MI	SPOUSE'S EMPLOYER		OCCUPATION
SPOUSE'S WORK ADDRESS		STREET	APT#	CITY	STATE	ZIP	WORK PHONE #
OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE					WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?		

**EMERGENCY CONTACT INFORMATION****PERSON WE MAY CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)**

NAME		RELATIONSHIP	
HOME PHONE #	WORK PHONE #	CELL PHONE #	

**REQUEST FOR CONFIDENTIAL COMMUNICATION****AS MY DENTAL CARE PROVIDER, YOU MAY DO THE FOLLOWING WITH MY PERMISSION:**

	YES	NO
Contact me at home		
Contact me via cell phone		
Contact me at work		
Contact me via e-mail		
Leave messages on my home voicemail / answering machine		
Leave messages on my cell phone voicemail		
Leave messages on my work voicemail / answering machine		

# INSURANCE AND FINANCIAL INFORMATION

<b>INSURANCE COVERAGE</b>	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
	<input type="checkbox"/> YES <input type="checkbox"/> NO		
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER	SUBSCRIBER'S BIRTHDAY	SUBSCRIBER'S SSN / ID #
	<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS	
<b>SECONDARY COVERAGE</b>	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
	<input type="checkbox"/> YES <input type="checkbox"/> NO		
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER	SUBSCRIBER'S BIRTHDAY	SUBSCRIBER'S SSN / ID #
	<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS	

## RELEASE INFORMATION

### YOU MAY DISCUSS MY HEALTHCARE WITH

	YES	NO	OTHERS (PLEASE PRINT)
Health Care Providers			1.
Insurance Companies			2.

## CONFIRMATIONS



### DO YOU PREFER A CONFIRMATION CALL

No, it is unnecessary

Yes, it is a helpful reminder

## ASSIGNMENT & RELEASE

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if he so determines. In consideration of the services rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.

I consent to making of videotapes, photographs, and x-rays before, during, and after treatment, and to use the same by the doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

SIGNATURE - PATIENT / GUARDIAN	DATE
WITNESS SIGNATURE	DATE