

**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	<input type="checkbox"/>	<input type="checkbox"/>
Contact me via cell phone	<input type="checkbox"/>	<input type="checkbox"/>
Contact me at work	<input type="checkbox"/>	<input type="checkbox"/>
Contact me via e-mail	<input type="checkbox"/>	<input type="checkbox"/>
Leave messages on my home voicemail / answering machine	<input type="checkbox"/>	<input type="checkbox"/>
Leave messages on my cell phone voicemail	<input type="checkbox"/>	<input type="checkbox"/>
Leave messages on my work voicemail / answering machine	<input type="checkbox"/>	<input type="checkbox"/>



**INSURANCE AND FINANCIAL INFORMATION**

<b>INSURANCE COVERAGE</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		SUBSCRIBER'S BIRTHDAY	SUBSCRIBER'S SSN / ID #
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS		
<b>SECONDARY COVERAGE</b> <input type="checkbox"/> YES <input type="checkbox"/> NO		INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		SUBSCRIBER'S BIRTHDAY	SUBSCRIBER'S SSN / ID #
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	<input type="checkbox"/>	<input type="checkbox"/>	1.
Insurance Companies	<input type="checkbox"/>	<input type="checkbox"/>	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