

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S NAME			LAST	FIRST	MIDDLE	DATE OF BIRTH	SEX	SOCIAL SECURITY #		
PATIENT'S ADDRESS			STREET	APT #	CITY	STATE	ZIP	EMAIL	HOME PHONE	
MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> UNDER AGE 18			PATIENT'S / GUARDIAN'S EMPLOYER				DRIVER'S LICENSE NUMBER			
WORK ADDRESS			STREET	CITY	STATE	ZIP	CELL PHONE	WORK PHONE	OK TO CALL AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
SPOUSE'S NAME			LAST	FIRST	MIDDLE	WHOM CAN WE THANK FOR REFERRING YOU TO US?				
WORK ADDRESS			STREET	CITY	STATE	ZIP	CELL PHONE	WORK PHONE	OK TO CALL AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
PERSON WE CAN CONTACT IN CASE OF EMERGENCY (OTHER THAN YOUR HOME) NAME						RELATIONSHIP	THEIR HOME #	THEIR WORK #	THEIR CELL #	

INSURANCE AND FINANCIAL INFORMATION

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

ASSIGNMENT & RELEASE:

I AM RESPONSIBLE FOR ALL BALANCES DUE WHETHER I HAVE INSURANCE OR NOT. I understand that the dental office will file any insurance on my behalf as a courtesy. I understand that my dentist has no control over how much my insurance will reimburse, since my insurance is a negotiated contract between my insurance company and me. I understand that my dental treatment will be rendered based on my particular dental needs, not based on any insurance reimbursement or coverage. I hereby authorize my insurance benefits to be paid directly to the dentist, and authorize the dentist to release any information for this claim, using my records as 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.

If I need to cancel an appointment, I will give at least 24 hours notice, or I will be subject to the prevailing missed appointment fee.

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 _____

Date _____