CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S LEGAL NAME LAST FIRST MIDDLE | DATE OF BIRTH | SEX ☐ MALE ☐ FEMALE

PREFER TO BE CALLED (OPTIONAL) | HOME PHONE # | CELL PHONE # | EMAIL ADDRESSES

YOUR ADDRESS STREET APT# CITY PROVINCE POSTAL CODE

MARITAL STATUS
☐ S ☐ M ☐ W ☐ D
☐ UNDER AGE 18

PATIENT'S / GUARDIAN'S EMPLOYER | OCCUPATION

WORK ADDRESS STREET UNIT CITY PROVINCE POSTAL CODE WORK PHONE # EXT.

SPOUSE'S NAME LAST, FIRST MI | SPOUSE'S EMPLOYER | OCCUPATION

WORK ADDRESS STREET UNIT CITY PROVINCE POSTAL CODE WORK PHONE # EXT.

OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE | HOW DID YOU FIND OUT ABOUT OUR OFFICE?

EMERGENCY CONTACT INFORMATION

NAME: | HOME PHONE # | CELL PHONE # | WORK PHONE # EXT.

RELATIONSHIP:

COMMUNICATIONS REQUEST

☐ Contact me at home ☐ Contact me at work ☐ Contact me by cellphone ☐ Contact me by email

DO YOU PREFER A COURTESY REMINDER CALL

☐ No, it is unnecessary ☐ Yes, it is a helpful reminder

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE ☐ YES ☐ NO | INSURANCE COMPANY NAME | INSURANCE ADDRESS | INSURANCE PHONE

SUBSCRIBER'S NAME | PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT | SUBSCRIBER'S BIRTHDAY | SUBSCRIBER'S SSN / ID #

GROUP / PROGRAM NUMBER | EMPLOYER (IF DIFFERENT FROM ABOVE) | EMPLOYER'S ADDRESS

INSURANCE COVERAGE ☐ YES ☐ NO | INSURANCE COMPANY NAME | INSURANCE ADDRESS | INSURANCE PHONE

SUBSCRIBER'S NAME | PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT | SUBSCRIBER'S BIRTHDAY | SUBSCRIBER'S SSN / ID #

GROUP / PROGRAM NUMBER | EMPLOYER (IF DIFFERENT FROM ABOVE) | EMPLOYER'S ADDRESS

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

SIGNATURE - PATIENT / GUARDIAN DATE

WITNESS SIGNATURE DATE