

# CONFIDENTIAL INFORMATION QUESTIONNAIRE

*Please Print*

PATIENT'S NAME		LAST	FIRST	MIDDLE	DATE OF BIRTH	SEX	SOCIAL SECURITY #
PATIENT'S ADDRESS		STREET	APT#	CITY	STATE	ZIP	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			OCCUPATION		
WORK ADDRESS		STREET	CITY	STATE	ZIP	WORK PHONE	OK TO CALL WORK <input type="checkbox"/> YES <input type="checkbox"/> NO
SPOUSE'S NAME		LAST	FIRST	MIDDLE	SPOUSE'S EMPLOYER		OCCUPATION
WORK ADDRESS		STREET	CITY	STATE	ZIP	WORK PHONE	OK TO CALL WORK <input type="checkbox"/> YES <input type="checkbox"/> NO
PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)							
NAME		RELATIONSHIP		WORK #		HOME#	
OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE				LET US KNOW HOW YOU HEARD ABOUT OUR OFFICE. TV NEWSPAPER MAIL FLYER YELLOW PAGES WEBSITE INSURANCE BILLBOARD OTHER _____			
<b>INSURANCE AND FINANCIAL INFORMATION</b>							
INSURANCE COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO		INSURANCE COMPANY NAME			INSURANCE ADDRESS		
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 SSN	
GROUP/PROGRAM NUMBER		EMPLOYER (IF DIFFERENT FROM ABOVE)			EMPLOYER ADDRESS		
SECONDARY COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO		INSURANCE COMPANY NAME			INSURANCE ADDRESS		
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 SSN	
GROUP/PROGRAM NUMBER		EMPLOYER (IF DIFFERENT FROM ABOVE)			EMPLOYER 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 consent to the making of videotapes, photographs, and x-rays before, during, and after treatment, and to the use of 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 \_\_\_\_\_ Date \_\_\_\_\_