

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 M S D W UNDER AGE 18	PATIENT'S/GUARDIAN'S EMPLOYER				OCCUPATION		
WORK ADDRESS	STREET	CITY	STATE	ZIP	CELL PHONE	WORK PHONE	OK TO CALL AT WORK? Y N
SPOUSE'S NAME		LAST	FIRST	MIDDLE	SPOUSE'S EMPLOYER	OCCUPATION	
WORK ADDRESS	STREET	CITY	STATE	ZIP	CELL PHONE	WORK PHONE	OK TO CALL AT WORK? Y N
PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)							
NAME		RELATIONSHIP		HOME#	WORK#	CELL#	
OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE					WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?		
INSURANCE AND FINANCIAL INFORMATION							
INSURANCE COVERAGE Y N	INSURANCE COMPANY NAME		ADDRESS			PHONE	
SUBSCRIBER'S NAME			PATIENT RELATIONSHIP TO SUBSCRIBER SELF SPOUSE DEPENDENT		SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN	
GROUP/PROGRAM NUMBER		EMPLOYER (IF DIFFERENT FROM ABOVE)			EMPLOYER ADDRESS		
SECONDARY COVERAGE Y N	INSURANCE COMPANY NAME		ADDRESS			PHONE	
SUBSCRIBER'S NAME			PATIENT RELATIONSHIP TO SUBSCRIBER SELF SPOUSE DEPENDENT		SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN	
GROUP/PROGRAM NUMBER		EMPLOYER (IF DIFFERENT FROM ABOVE)			EMPLOYER ADDRESS		

ASSIGNMENT & RELEASE:

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 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 _____