

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S LEGAL NAME		LAST,	FIRST	MI	DATE OF BIRTH	SEX	SSN(US) / SIN(CAN)
PREFER TO BE CALLED				HOME PHONE #		CELL PHONE #	
PATIENT'S ADDRESS		STREET	APT#	CITY	STATE	ZIP/POSTAL CODE	E-MAIL
MARITAL STATUS		PATIENT'S / GUARDIAN'S EMPLOYER				OCCUPATION	
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WORK ADDRESS		STREET	APT#	CITY	STATE	ZIP/POSTAL CODE	WORK PHONE #
SPOUSE'S NAME		LAST,	FIRST	MI	SPOUSE'S EMPLOYER		OCCUPATION
SPOUSE'S WORK ADDRESS		STREET	APT#	CITY	STATE	ZIP/POSTAL CODE	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="radio"/>	<input type="radio"/>
Contact me via cell phone	<input type="radio"/>	<input type="radio"/>
Contact me at work	<input type="radio"/>	<input type="radio"/>
Contact me via e-mail	<input type="radio"/>	<input type="radio"/>
Leave messages on my home voicemail / answering machine	<input type="radio"/>	<input type="radio"/>
Leave messages on my cell phone voicemail	<input type="radio"/>	<input type="radio"/>
Leave messages on my work voicemail / answering machine	<input type="radio"/>	<input type="radio"/>

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
	<input type="radio"/> YES <input type="radio"/> NO		
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER	SUBSCRIBER'S BIRTHDAY	SSN(US) / SIN(CAN)
<input type="radio"/> SELF <input type="radio"/> SPOUSE <input type="radio"/> DEPENDENT			
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS	
SECONDARY COVERAGE	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
	<input type="radio"/> YES <input type="radio"/> NO		
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER	SUBSCRIBER'S BIRTHDAY	SSN(US) / SIN(CA)
<input type="radio"/> SELF <input type="radio"/> SPOUSE <input type="radio"/> DEPENDENT			
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="radio"/>	<input type="radio"/>	1.
Insurance Companies	<input type="radio"/>	<input type="radio"/>	2.

CONFIRMATIONS



DO YOU PREFER A CONFIRMATION CALL

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

ASSIGNMENT & RELEASE

I hereby authorize (1) any available insurance benefits to be paid directly to my dentist, (2) the release of my dental health care information for any of my dental health care insurance claim, (3) the use of my dental records by my dentist in any professional manner that he/she determines, (4) the making of videotapes, photographs, and x-rays of my dental care treatment (collectively "My Images"), and (5) my dentist's use of My Images in scientific papers, demonstrations and/or presentations without compensation to me. I agree that to the extent the cost of the dental care provided by my dentist is not covered by insurance, I am obligated to pay him/her such uninsured cost (the "Uninsured Costs") in accordance with his/her payment terms and policies. Finally, I certify that I have read or had read to me the contents of this form and understand the risks and limitations involved with the dental treatment that I am to receive.

SIGNATURE - PATIENT / GUARDIAN	DATE
WITNESS SIGNATURE	DATE
If the above named Patient is a minor or unable to pay the his/her Uninsured Costs, the undersigned agrees to guaranty the payment of such Uninsured Costs to the Patient's dentist in accordance with his/her payment terms and policies.	
SIGNATURE - GUARANTOR OF PATIENT	DATE