CONFIDENTIAL INFORMATION QUESTIONAIRE

NAME: LAST FIRST MIDDLE DATE OF BIRTH SEX ☐MALE /☐FEMALE SOCIAL SECURITY #

ADDRESS: STREET APT# CITY STATE PREFERRED PHONE #

EMAIL ADDRESS: (if you would like email reminders) MARITAL STATUS: ☐SINGLE ☐MARRIED ☐WIDOWED ☐CHILD

EMPLOYER / GUARDIAN'S EMPLOYER WORK ADDRESS: WORK PHONE: (ok to contact you at work?)

SPOUSES NAME: SPOUSE'S D.O.B.

EMERGENCY CONTACT : PHONE: RELATIONSHIP:

OTHER FAMLY MEMEBERS THAT ARE PATIENTS HERE: * ***WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE***

INSURANCE AND/OR FINANCIAL INFORMATION

INSURANCE COVERAGE ☐YES ☐NO INSURANCE CO. NAME: ADDRESS: PHONE:

SUBSCRIBERS'S NAME: PATIENT'S RELATIONSHIP TO SUBSCIBER ☐SELF ☐SPOUSE ☐DEPENDENT SUBSCRIBER'S DATE OF BIRTH

SUBSCRIBER'S SS# GROUP # EMPLOYER (if different from above)

SECONDARY COVERAGE ☐YES ☐NO INSURANCE CO. NAME: ADDRESS: PHONE:

SUBSCRIBER'S NAME: PATIENT'S RELATIONSHIP TO SUBSCIBER ☐SELF ☐SPOUSE ☐DEPENDENT SUBSCRIBERS D.O.B. SUBSCRIBERS SS#

GROUP NUMBER EMPLOYER (if different from above) EMPLOYER ADDRESS

ASSIGNMENT AND RELEASE:

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due and authorize the dentist 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 also understand that I am obligated to pay co-pays and deductibles at the time of service as required by my insurance company.

I consent to making of videotapes, photographs, and x-rays before, during, and after treatment, and to the use of the 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: _____