

# 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<br><input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W<br><input type="checkbox"/> UNDER AGE 18 |  | PATIENT'S/GUARDIAN'S EMPLOYER |       |  |                   | OCCUPATION |                   |   |  |
| WORK ADDRESS   |  | STREET                        | CITY  | STATE  | ZIP               | CELL PHONE | WORK PHONE        | OK TO CALL WORK<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| SPOUSE'S NAME  |  | LAST                          | FIRST | MIDDLE   | SPOUSE'S EMPLOYER |            | OCCUPATION        |   |  |
| WORK ADDRESS   |  | STREET                        | CITY  | STATE  | ZIP               | CELL PHONE | WORK PHONE        | OK TO CALL WORK<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  |
| 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 CAN WE THANK FOR REFERRING YOU TO OUR OFFICE |                   |            |                   |   |  |

## INSURANCE AND FINANCIAL INFORMATION

|  |  |  |  |                            |                  |                  |       |  |
|--|--|--|--|----------------------------|------------------|------------------|-------|--|
| INSURANCE COVERAGE<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | INSURANCE COMPANY NAME   |  |                            | ADDRESS          |                  | PHONE |  |
| SUBSCRIBER'S NAME  |  | PATIENT'S RELATIONSHIP TO SUBSCRIBER<br><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<br><input type="checkbox"/> YES <input type="checkbox"/> NO |  | INSURANCE COMPANY NAME   |  |                            | ADDRESS          |                  | PHONE |  |
| SUBSCRIBER'S NAME  |  | PATIENT'S RELATIONSHIP TO SUBSCRIBER<br><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 \_\_\_\_\_