

CONFIDENTIAL INFORMATION QUESTIONNAIRE

Please Print

PATIENT'S NAME	LAST	FIRST	MIDDLE	DATE OF BIRTH	SEX	SOCIAL SECURITY#
NICKNAME						
PATIENT'S ADDRESS		STREET		CITY	STATE	ZIP
HOME PHONE ()						
CELL PHONE ()		E-MAIL ADDRESS		PAGER ()		WORK PHONE ()
MARITAL STATUS	PATIENT / GUARDIAN EMPLOYER				OCCUPATION	
<input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W						
WORK ADDRESS						
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				WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE		
INSURANCE AND FINANCIAL INFORMATION						
RESPONSIBLE PARTY			INSURANCE COVERAGE		INSURANCE COMPANY NAME	
			<input type="checkbox"/> YES <input type="checkbox"/> NO			
SUBSCRIBER'S NAME		PATIENT'S RELATIONSHIP TO SUBSCRIBER		SUBSCRIBER'S DATE OF BIRTH		SUBSCRIBER'S SSN
		<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT				
GROUP / PROGRAM NUMBER		EMPLOYER (IF DIFFERENT FROM ABOVE)			EMPLOYER ADDRESS	
SECONDARY COVERAGE		INSURANCE COMPANY NAME			INSURANCE ADDRESS	
<input type="checkbox"/> YES <input type="checkbox"/> NO						
SUBSCRIBER'S NAME		PATIENT'S RELATIONSHIP TO SUBSCRIBER		SUBSCRIBER'S DATE OF BIRTH		SUBSCRIBER'S SSN
		<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT				
GROUP / PROGRAM NUMBER		EMPLOYER (IF DIFFERENT FROM ABOVE)			EMPLOYER ADDRESS	

ASSIGNMENT & 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 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 certify that I have read or had read to me the contents of this form and realize the risks and limitations involved.

Signature _____ Date _____