Confidential Information Questionnaire

Full Name

Address

City, State, Zip

Date of Birth

○ Male ○ Married ○ Single
○ Female ○ Divorced ○ Widowed ☐ Under 18

Social Security #

Home Phone

Cell Phone

Email Address

Patient's / Guardian's Employer

Occupation

Work Address

Work Phone

OK to call work

○ **Yes** ○ **No**

Spouse's Name

Spouse's Employer

Occupation

Work Address

Work Phone

OK to call work

○ **Yes** ○ **No**

Cell Phone

Emergency Contact

Name *in Case of Emergency (other than your family home)*

Relationship

Home #

Work #

Other family members that are patients here

Who we can thank for referring you to our office

Insurance and Financial Information

Insurance Coverage ○ **Yes** ○ **No**

Insurance Company Name	**Address**	**Phone Number**	**Subscriber's ID#**

Subscriber's Date of Birth	**Subscriber's Name**	**Patient's Relationship to Subscriber** ○ Self ○ Spouse ○ Dependent

Group/Program Number	**Employer (if different from above)**	**Employer Address**

Secondary Coverage ○ **Yes** ○ **No**

Insurance Company Name	**Address**	**Phone Number**	**Subscriber's ID#**

Subscriber's Date of Birth	**Subscriber's Name**	**Patient's Relationship to Subscriber** ○ Self ○ Spouse ○ 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 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** __________________