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 ☐ S ☐ M ☐ W ☐ D ☐ UNDER AGE 18	PATIENT'S / GUARDIAN'S EMPLOYER	OCCUPATION

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	☐	☐
Contact me via cell phone	☐	☐
Contact me at work	☐	☐
Contact me via e-mail	☐	☐
Leave messages on my home voicemail / answering machine	☐	☐
Leave messages on my cell phone voicemail	☐	☐
Leave messages on my work voicemail / answering machine	☐	☐

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE ☑ YES ☐ NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☑ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S BIRTHDAY	SSN(US) / SIN(CAN)
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS	

SECONDARY COVERAGE ☑ YES ☐ NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S BIRTHDAY	SSN(US) / SIN(CA)
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS	

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTHCARE WITH

	YES	NO
Health Care Providers	☐	☑
Insurance Companies	☐	☑

OTHERS (PLEASE PRINT)

1.

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 in connection with any insurance claim for such care, (3) my dentist to use my dental records in any professional manner that he/she so determines, (4) the making of videotapes, photographs, and x-rays of the dental treatment that I receive before, during and after such treatment (collectively "My Images"), and (5) my dentist to use My Images in scientific papers, demonstrations and/or presentations without compensation to me. If I am signing this form as the guardian of a patient then the above authorization is on behalf of such patient.

I acknowledge and agree that if certain costs of my dental care is not covered by insurance, I am financially responsible and obligated to pay my dentist such uninsured cost in accordance with the payment terms and policies of my dentist. If I am signing this form as the guardian of the dentist's patient, the dentist agrees that my signature does not make me personally liable for the payment of any uninsured costs.

Finally, I by signing below I acknowledge my understanding of the risks and limitations involved with the dental treatment that I am to receive or that the patient is to receive if I am signing as such patient's guardian.

SIGNATURE - PATIENT / GUARDIAN	DATE
WITNESS SIGNATURE	DATE