CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S NAME LAST FIRST MIDDLE	DATE OF BIRTH	SEX	SSN
PATIENT'S ADDRESS STREET APT# CITY STATE ZIP			HOME PHONE
MARITAL STATUS (CIRCLE ONE) M S D W	PATIENT'S EMPLOYER	OCCUPATION	CELL PHONE
WORK ADDRESS STREET CITY STATE ZIP			WORK PHONE
SPOUSE'S NAME LAST FIRST MIDDLE	SPOUSE'S EMPLOYER		Patient Email Address
WORK ADDRESS STREET CITY STATE ZIP			WORK PHONE
EMERGENCY PERSON WE CAN CONTACT (OTHER THAN YOUR FAMILY HOME) NAME WORK PHONE HOME PHONE			
NAMES OF OTHER FAMILY MEMBERS WHO ARE PATIENTS HERE	WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?		

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE (CIRCLE ONE) YES NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS	
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER (CIRCLE ONE) SELF SPOUSE DEPENDENT	SUBSCRIBER'S DATE OF BIRTH	SSN
GROUP PROGRAM NUMBER	EMPLOYER – IF DIFFERENT FROM ABOVE	EMPLOYER'S ADDRESS	
SECONDARY COVERAGE (CIRCLE ONE) YES NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS	
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER (CIRCLE ONE) SELF SPOUSE DEPENDENT	SUBSCRIBER'S DATE OF BIRTH	SSN
GROUP PROGRAM NUMBER	EMPLOYER – IF DIFFERENT FROM ABOVE	EMPLOYER'S 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 dentist to release any information required for this claim. I authorize that my records can be used by the doctor if he so determines.

In consideration of the service 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 taking of 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 _____