

## Confidential Information Questionnaire

\_\_\_\_\_  
Patient's Legal Name                      Last                      First                      MI                      Date of Birth

\_\_\_\_\_  
Social Security Number (Last Four Digits)

Gender  
M  F

\_\_\_\_\_  
Prefer to be called

\_\_\_\_\_  
Home Phone #

\_\_\_\_\_  
Work Phone#

\_\_\_\_\_  
Cell Phone #

\_\_\_\_\_  
Patient's Address    Street    Apt #    City    State    Zip

\_\_\_\_\_  
Email

Marital Status    S     M     W     D

Spouses Name and Employer \_\_\_\_\_

Other family members that are patients here \_\_\_\_\_

Who can we thank for referring you to our office? \_\_\_\_\_

Under 18

Parent/Guardian: \_\_\_\_\_

( Complete if patient is under 18 or on your insurance )

### Insurance and Financial Information

Insurance Coverage    Y     N

\_\_\_\_\_  
Insurance Company's Name

\_\_\_\_\_  
Insurance Claims Address

\_\_\_\_\_  
Insurance Phone Number

\_\_\_\_\_  
Subscriber's Name

Patient's relationship to subscriber  
Self     Spouse     Dependant

\_\_\_\_\_  
Subscriber's birthday

Subscriber's SSN or Insurance ID # \_\_\_\_\_

Group / Program Number \_\_\_\_\_                      Employer \_\_\_\_\_

Secondary Coverage    Y     N

Insurance Company's Name \_\_\_\_\_

Insurance Claims Address \_\_\_\_\_

Insurance Phone Number \_\_\_\_\_

Subscriber's Name \_\_\_\_\_

Self  Spouse  Dependant   
Patient's relationship to subscriber

Subscriber's Birthday \_\_\_\_\_

Subscriber's SSN or Insurance ID # \_\_\_\_\_

### Emergency Contact Information

Person we may contact in case of an emergency (other than your family home)

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home Phone Number \_\_\_\_\_

Work Phone Number \_\_\_\_\_

Cell Phone Number \_\_\_\_\_

### Request for Confidential Communication

As my dental care provider, you may do the following with my permission

Y N

Contact me at home

Contact me via cell phone

Contact me at work

Contact me via text

Contact me via email

### Assignment & Release

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balance due and authorize the dentists to release any information for claims. I authorize that my records can be used by the doctor if they so determine. In consideration of the services rendered to me by the dental office, I am obligated to pay said office in accordance with its credit terms and policy.

I consent to making of videotapes, photographs, and x-rays before, during, and after treatment to be used by the doctor in scientific papers, demonstrations, presentations, laboratory communication and or social media which includes but is not limited to their Facebook page. These videos will not be use for other commercial purposes. These images will become property of my dental record.

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

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_ Witness \_\_\_\_\_ Date \_\_\_\_\_

Parent/Guardian Signature (patient under 18) \_\_\_\_\_ Date \_\_\_\_\_