

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S LEGAL NAME		LAST	FIRST	MI	DATE OF BIRTH	SEX	Personal Health Number (PHN)
PREFER TO BE CALLED				HOME PHONE #		CELL PHONE #	
PATIENT'S ADDRESS		STREET	APT#	CITY	STATE	ZIP/POSTAL CODE	E-MAIL
MARITAL STATUS		PATIENT'S / GUARDIAN'S EMPLOYER				OCCUPATION	
S M W D UNDER AGE 18							
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		
Leave messages on my cell phone voicemail		
Leave messages on my work voicemail		

INSURANCE AND FINANCIAL INFORMATION

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

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTHCARE WITH

	YES	NO	OTHERS (PLEASE PRINT)
Health Care Providers			1.
Insurance Companies			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 for any of my dental health care insurance claim, (3) the use of my dental records by my dentist in any professional manner that he/she determines, (4) the making of videotapes, photographs, and x-rays of my dental care treatment (collectively "My Images"), and (5) my dentist's use of My Images in scientific papers, demonstrations and/or presentations without compensation to me. I agree that to the extent the cost of the dental care provided by my dentist is not covered by insurance, I am obligated to pay him/her such uninsured cost (the "Uninsured Costs") in accordance with his/her payment terms and policies. Finally, I certify that I have read or had read to me the contents of this form and understand the risks and limitations involved with the dental treatment that I am to receive.

SIGNATURE - PATIENT / GUARDIAN	DATE
WITNESS SIGNATURE	DATE
If the above named Patient is a minor or unable to pay the his/her Uninsured Costs, the undersigned agrees to guaranty the payment of such Uninsured Costs to the Patient's dentist in accordance with his/her payment terms and policies.	
SIGNATURE - GUARANTOR OF PATIENT	DATE