CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S NAME LAST FIRST MIDDLE	DATE OF BIRTH	SEX	SOCIAL SECURITY #

PATIENT'S ADDRESS STREET APT # CITY STATE ZIP	EMAIL	HOME PHONE

MARITAL STATUS □ M □ S □ D □ W □ UNDER AGE 18	PATIENT'S / GUARDIAN'S EMPLOYER	DRIVER'S LICENSE NUMBER

WORK ADDRESS STREET CITY STATE ZIP	CELL PHONE	WORK PHONE	OK TO CALL AT WORK? □ YES □ NO

SPOUSE'S NAME LAST FIRST MIDDLE	WHOM CAN WE THANK FOR REFERRING YOU TO US?

WORK ADDRESS STREET CITY STATE ZIP	CELL PHONE	WORK PHONE	OK TO CALL AT WORK? □ YES □ NO

PERSON WE CAN CONTACT IN CASE OF EMERGENCY (OTHER THAN YOUR HOME) NAME RELATIONSHIP	THEIR HOME #	THEIR WORK #	THEIR CELL #

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE □ YES □ NO	INSURANCE COMPANY NAME	ADDRESS	PHONE

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER □ SELF □ SPOUSE □ DEPENDENT	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SOCIAL SECURITY #

GROUP/PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER ADDRESS

COVERAGE □ YES □ NO SECONDARY	INSURANCE COMPANY NAME	ADDRESS	PHONE

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER □ SELF □ SPOUSE □ DEPENDENT	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SOCIAL SECURITY #

GROUP/PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER ADDRESS

ASSIGNMENT & RELEASE:

I AM RESPONSIBLE FOR ALL BALANCES DUE WHETHER I HAVE INSURANCE OR NOT. I understand that the dental office will file any insurance on my behalf as a courtesy. I understand that my dentist has no control over how much my insurance will reimburse, since my insurance is a negotiated contract between my insurance company and me. I understand that my dental treatment will be rendered based on my particular dental needs, not based on any insurance reimbursement or coverage. I hereby authorize my insurance benefits to be paid directly to the dentist, and authorize the dentist to release any information for this claim, using my records as 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.

If I need to cancel an appointment, I will give at least 24 hours notice, or I will be subject to the prevailing missed appointment fee.

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____________________