IMPORTANT

Please Read

In order to successfully submit these forms online it will require you to use the Adobe Acrobat Reader plugin for your web browser. If you do not have that you can click the link below and install it.

If you attempt to fill out these forms and submit them online using Adobe Acrobat Reader itself, or another similar utility, this will fail.

However, if you wish you can print out the forms using Adobe Acrobat Reader, or another similar utility, fill them out and bring them to your appointment.

Thank you for your cooperation.

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	OCCUPATION

WORK ADDRESS STREET CITY STATE ZIP	CELL PHONE	WORK PHONE	OK TO CALL WORK ❑ YES ❑ NO

SPOUSE'S NAME LAST FIRST MIDDLE	SPOUSE'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET CITY STATE ZIP	CELL PHONE	WORK PHONE	OK TO CALL WORK ❑ YES ❑ NO

PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME	RELATIONSHIP	HOME #	WORK #	CELL #

OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE	WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE

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 SSN

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

SECONDARY 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 SSN

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

ASSIGNMENT & RELEASE:

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records can be used by the doctor if 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.

I consent to the making of videotapes, 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 ______________________

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