I. Confidential Information Questionnaire

Patient's Legal Name: First Last Middle

Nickname

Date of Birth: Sex: Male Female

Cell Phone: (201) 555-0123

Email Address

Home Phone Number (201) 555-0123

Work Phone Number (201) 555-0123

Patient's Address

United States Address line 1 Address line 2 City

State/Province Zip/Postal Code

Marital Status

Single Married / Common-law partner Widowed Divorced / Separated Under 18

Prefer not to answer

Who can we thank for referring you to our office?

Employer (Patient's / Guardian's) Full Name

Occupation

II. Emergency Contact Information

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

Name

Relationship

Cell Phone Number (201) 555-0123

Home Phone Number (201) 555-0123

Work Phone Number (201) 555-0123

III. Request For Confidential Communication

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

- [ ] Check all
- [ ] Leave message on my voicemail / answering machine
- [ ] Contact me via email
- [ ] Contact me on the phone numbers provided

- [ ] I agree that the dental practice may communicate with me electronically at the email address and cell phone number i provided. I am aware that there is some level of risk that third parties might be able to read unencrypted emails or text messages.I am responsible for providing the dental practice any updates to my email address and cell phone number.
  I can withdraw my consent to electronic communications by contacting the dental office

IV. Confirmation

Do you prefer a reminder before you appointment ☐ No, it is unnecessary ☐ Yes, it is a helpful reminder

V. Dental Insurance And Financial Information

Dental Insurance Coverage ☐ Yes ☐ No

Dental insurance Company Name _____

Dental insurance Address _____

Dental insurance Phone Number (201) 555-0123 _____

Subscriber's Name Full Name _____

Subscriber's ID Subscriber ID _____

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Dependent

Subscriber's Birthday _____

Subscriber's Address

Country ▾ Address line 1 _____ Address line 2 _____ City _____

State/Province _____ Zip/Postal Code _____

Group / Program Number _____

Employer (if different from above) _____

Employer's Address

Secondary Coverage ☐ Yes ☐ No

Dental insurance Company Name

Dental insurance Address

Dental insurance Phone Number (201) 555-0123

Subscriber's Name Full Name

Subscriber's ID Subscriber ID

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Dependent

Subscriber's Birthday Day Year

Subscriber's Address

Country Address line 1 Address line 2 City

State/Province Zip/Postal Code

Group / Program Number

Employer (if different from above)

Employer's Address

VI. Release Information

You may discuss my healthcare with

☐ Spouse / Common-law partner

☐ Children

☐ Parents

Others: 1.

VII. Assignment & Release

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my

insurance submissions whether manual or electronic. I hereby authorize any available insurance benefits to be paid directly to my dentist if he/she accepts such an arrangement.

☐ I confirm that I have read and understood the terms & conditions.

I hereby authorize the making of videotapes, photographs, and x-rays of my dental care treatment (collectively “My Images”), and my dentist’s use of My Images in scientific papers, demonstrations and/or presentations without compensation to me.

☐ I confirm that I have read and understood the terms & conditions.

Patient Signature

Date