# CONFIDENTiAL INFORMATION QUESTIONNAIRE

**Patient's Name:** _____ **Date:** _____
First Middle Last

**Address:** _____ **City:** _____ **ST:** ____ **Zip:**_____

**Home Phone:** _____ **Work Phone:** _____ **Cell Phone:** _____

**Social Security No:** _____ **Date of Birth:** _____ **Sex:** ❑ **M** ❑ **F**

**Parent or Guardian (If Child):** _____ **Marital Status:** ❑ **S** ❑ **M** ❑ **D** ❑ **W**

**Spouse's Name:** _____ **Your Occupation:** _____

**Emergency Contact:** _____ **Phone:** _____

**Your e-mail address:** _____ **Who can we thank for referring you:** _____

## INSURANCE AND FINANCIAL INFORMATION

**Person Financially Responsible for Account:** _____ **Relationship:** _____

**Insurance Coverage:** ❑ **Yes** ❑ **No** **Insurance Co:** _____ **Group No:** _____

**Subscriber's Name:** _____ **Social Security/ID:** _____

**Date of Birth:** _____ **Patient's Relationship to Insured:** ❑ **Self** ❑ **Spouse** ❑ **Dependent**

**Employer:** _____ **Address:** _____

**Secondary Coverage:** ❑ **Yes** ❑ **No** **Insurance Co:** _____ **Group No:** _____

**Subscriber's Name:** _____ **Social Security/ID:** _____

**Date of Birth:** _____ **Patient's Relationship to Insured:** ❑ **Self** ❑ **Spouse** ❑ **Dependent**

**Employer:** _____ **Address:** _____

**ASSIGNMENT AND RELEASE:**

I hereby authorize my insurance benefits to be paid directly to the dentist(s). I am financially responsible for any balances due and authorize the dentists to release any information for my claims. I authorize that my records can be used by the doctor if he so determines.

I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 ½% late charge (18% APR) may be added to my account.

**Signature:** _____ **Date:** _____