



CONFIDENTIAL INFORMATION QUESTIONNAIRE

Welcome! Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Please Print

PATIENT'S NAME		LAST	FIRST	MIDDLE	DATE OF BIRTH	SEX	SOCIAL SECURITY #
PATIENT'S ADDRESS		STREET	APT #	CITY	STATE	ZIP	HOME PHONE
RESPONSIBLE PARTY				RELATIONSHIP TO PATIENT			
DRIVER'S LICENSE # OF RESPONSIBLE PARTY				STATE LICENSE ISSUED IN			
MARITAL STATUS <input type="checkbox"/> M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> UNDER AGE 18		PATIENT'S/GUARDIAN'S EMPLOYER			OCCUPATION		
WORK ADDRESS		STREET	CITY	STATE	ZIP	WORK PHONE	OK TO CALL WORK <input type="checkbox"/> YES <input type="checkbox"/> NO
SPOUSE'S NAME		LAST	FIRST	MIDDLE	SPOUSE'S EMPLOYER		OCCUPATION
WORK ADDRESS		STREET	CITY	STATE	ZIP	WORK PHONE	OK TO CALL WORK <input type="checkbox"/> YES <input type="checkbox"/> NO
IF STUDENT, NAME OF SCHOOL/COLLEGE			CITY	STATE	<input type="checkbox"/> FULL TIME <input type="checkbox"/> PART TIME		
PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)							
NAME		RELATIONSHIP			HOME #		
WORK #							
OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE				WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE			
INSURANCE COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO		INSURANCE COMPANY NAME			INSURANCE PHONE		
		INSURANCE ADDRESS					
NAME OF INSURED <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		RELATIONSHIP TO INSURED		INSURED DATE OF BIRTH		INSURED S.S.N.	
GROUP/POLICY NUMBER		EMPLOYER (IF DIFFERENT FROM ABOVE)			EMPLOYER ADDRESS		
SECONDARY COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO		INSURANCE COMPANY NAME			INSURANCE PHONE		
		INSURANCE ADDRESS					
NAME OF INSURED <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT		RELATIONSHIP TO INSURED		INSURED DATE OF BIRTH		INSURED S.S.N.	
GROUP/POLICY NUMBER		EMPLOYER (IF DIFFERENT FROM ABOVE)			EMPLOYER ADDRESS		

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge.

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered.

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

Signature _____ Date _____ Dental Personnel Initials: _____