

**.PATIENT INFORMATION QUESTIONNAIRE**

Name \_\_\_\_\_ Preferred Name \_\_\_\_\_

S.S. # \_\_\_\_\_ D.O.B. \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Home# \_\_\_\_\_ Cell# \_\_\_\_\_ Work # \_\_\_\_\_

**Email:** \_\_\_\_\_ Best time and # to contact you: \_\_\_\_\_

Marital Status: S M W D Sex: M F CA Driver's License # \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_

Business Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Dental Insurance \_\_\_\_\_ Subscriber \_\_\_\_\_ Group# \_\_\_\_\_

.....  
Spouse's Name (Parent or Legal Guardian if a minor) \_\_\_\_\_

Spouse's D.O.B. \_\_\_\_\_ Spouse's CA Driver's License # \_\_\_\_\_

Spouse's S.S.# \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Spouse's Business # \_\_\_\_\_

Spouse's Dental Insurance \_\_\_\_\_ Group \_\_\_\_\_

.....  
General Dentist \_\_\_\_\_ City \_\_\_\_\_

How long have you been seeing him/her? \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

.....  
Physician \_\_\_\_\_ Phone \_\_\_\_\_

Address \_\_\_\_\_

Date of Last Physical \_\_\_\_\_

.....  
Who do we contact in case of an emergency? \_\_\_\_\_

Phone \_\_\_\_\_

.....  
I understand that the treatment recommended is based on your professional judgment about what is in my long-term best interest and not on whether or not I am covered by a dental insurance plan.

I understand that my insurance carrier has limitations and I authorize the use of my social security number to submit all insurance claims as a courtesy to me. I understand that your estimate of my insurance coverage is only an estimate and not a guarantee of payment. I understand that payment may be reduced by deductibles, coordination of benefits with another carrier, expenses that may be paid before these services are rendered and my claim is submitted and other plan limitations in effect when services are actually performed. I hereby authorize payment directly to Denine T. Rice, D.D.S., M.S., INC. otherwise payable to me. A photocopy of this document may act as an original.

Appointments not kept or cancelled within **48 hours** of appointment time are subject to a **cancellation fee** of \$100 per every hour scheduled with the hygienist and \$150 per every half hour scheduled with the doctor.

I understand that all responsibility for payment for dental services provided in this office for my dependents or I am due and payable at the time services are rendered. In the event payments are not received by the agreed upon dates, I understand that a 2% finance charge (18% APR) may be added to my account, in addition to any collection charges. I understand that where appropriate, credit bureau reports may be obtained.

I understand and accept the prescribed periodontal treatment and accept the financial obligations should I chose to have the treatment rendered.

I have received a copy of this office's Notice of Privacy Practices.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_