

CONFIDENTIAL INFORMATION QUESTIONNAIRE

Patients Name _____

Date of Birth _____ Sex M/F Email Address _____

Address _____ City/Prov _____

Postal Code _____

Home Phone _____ Cell Phone _____ OK to call Yes/No

Work Phone _____ (Okay to call Yes/No)

Occupation _____ Employer _____

Emergency Contact Person _____

INSURANCE AND FINANCIAL INFORMATION

Insurance coverage YES / NO

Insurance Company _____

Name of Insured _____ Relationship _____

Insured Employer _____ Date of Birth _____

Group/Policy # _____ Certificate/ID # _____

Assignment and Release

I hereby authorize my insurance benefits to be paid directly to the dentist. I (or my guardian) 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 photographs and xrays before, during and after treatment and to the use of same by the dentist in specific papers or demonstrations.

I certify that I have read or had read to me the consent of this form and do realize the risks and limitations involved.

Signature _____ Date _____