CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S NAME LAST FIRST MIDDLE	DATE OF BIRTH	SEX	SOCIAL SECURITY #

PATIENTS ADDRESS STREET APT# CITY STATE ZIP	EMAIL	HOME PHONE

MARITAL STATUS M S D W UNDER AGE 18	PATIENT'S GUARDIAN'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET CITY STATE ZIP	CELL PHONE	WORK PHONE	OK TO CALL WORK
			YES NO

SPOUSE'S NAME LAST FIRST MIDDLE	SPOUSE'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET CITY STATE ZIP	CELL PHONE	WORK PHONE	OK TO CALL WORK
			YES NO

PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME	RELATIONSHIP	HOME#	WORK#	CELL#

OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE	WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE

INSURANCE FINANCIAL INFORMATION

INSURANCE COVERAGE YES NO	INSURANCE COMPANY NAME	ADDRESS	PHONE

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF SPOUSE DEPENDENT	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN

GROUP/PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER ADDRESS

SECONDARY COVERAGE YES NO	INSURANCE COMPANY NAME	ADDRESS	PHONE

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF SPOUSE DEPENDENT	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN

GROUP/PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER ADDRESS

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Patient Signature _____ Date _____

CONSENT:

1. The undersigned hereby authorizes doctor to take x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by doctors to make a thorough diagnosis of the patient's dental needs.
2. I also authorize doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patients) _____ . I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. Lastly, I understand that all responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1-1/2% finance charge (18% APR) may be added to my account.

Patient _____ Date _____ Witness _____

Parent or Responsible Party _____ Relationship of Patient _____