SMILEDESIGNER

Team of Dental Specialists

# CONFIDENTIAL INFORMATION QUESTIONAIRE

| PATIENT'S NAME LAST FIRST MIDDLE | DATE OF BIRTH | SEX | SOCIAL SECURITY # |
|---|---|---|---|
| PATIENT'S ADDRESS STREET APT# CITY STATE ZIP | | | |

| EMAIL | HOME PHONE | CELL PHONE |
|---|---|---|
| MARITAL STATUS<br>☐ M ☐ S ☐ D ☐ W ☐ UNDER AGE 18 | PATIENT'S/ GUARDIAN'S EMPLOYER | OCCUPATION |

| WORK ADDRESS STREET CITY STATE ZIP | WORK PHONE | OK TO CALL WORK<br>☐ YES ☐ NO |
|---|---|---|

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

| SPOUSE'S CELL | SPOUSE'S WORK | SPOUSE'S EMAIL | OK TO CALL WORK<br>☐ YES ☐ NO |
|---|---|---|---|

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

| NAME | RELATIONSHIP | HOME# | CELL# | WORK# |
|---|---|---|---|---|

| OTHER FAMILY MEMEBERS THAT ARE PATIENTS HERE? | WHO CAN WE THANK FOR REFERRING YOU TO OUR PRACTICE? |
|---|---|

## INSURANCE AND FINANCIAL INFORATION

| INSURANCE COVERAGE<br>☐ YES ☐ NO | INSURANCE COMPANY NAME | ADDRESS | PHONE# |
|---|---|---|---|

| SUBSCRIBER'S NAME | PATIENT'S RELATIONSHIP TO SUBSCRIBER<br>☐ SELF ☐ SPOUSE ☐ DEPENDENT | SUBSCRIBER'S DATE OF BIRTH | SUBSCRIBER'S SSN |
|---|---|---|---|

| GROUP/PROGRAM # | ID/MEMBER/POLICY NUMBER # | POLICY HOLDER'S EMPLOYER (IF DIFFERENT FROM ABOVE) |
|---|---|---|

| SECONDARY COVERAGE<br>☐ YES ☐ NO | INSURANCE COMPANY NAME | ADDRESS | PHONE# |
|---|---|---|---|

| SUBSCRIBER'S NAME | PATIENT'S RELATIONSHIP TO SUBSCRIBER<br>☐ SELF ☐ SPOUSE ☐ DEPENDENT | SUBSCRIBER'S DATE OF BIRTH | SUBSCRIBER'S SSN |
|---|---|---|---|

| GROUP/PROGRAM # | ID/MEMBER/POLICY NUMBER # | POLICY HOLDER'S EMPLOYER (IF DIFFERENT FROM ABOVE) |
|---|---|---|

### ASSIGNMENT & RELEASE:

I hereby authorize my insurance benefits to be paid directly to the dentists. I 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/she so determines.

In consideration of the services rendered to me by this dental practice I am obligated to pay said office in accordance with its credit terms and policy.

I consent to the making of videotapes, photographs, and x-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.

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

**Signature** ____________________________________ **Date** ______________________