CONFIDENTIAL INFORMATION QUESTIONNAIRE

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

PATIENT'S 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

ASSIGNMENT & RELEASE

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due and authorize the dentist to release any information for this claim.

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 the making of photographs and x-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers and/or consultations with other medical professionals.

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**_____________________________