

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT NAME LAST FIRST MIDDLE				DATE OF BIRTH	SOCIAL SECURITY #
PATIENT ADDRESS				HOME PHONE #	
EMAIL				CELL PHONE #	
SPOUSE'S NAME				SPOUSE'S CONTACT #	
EMPLOYER		OK TO CALL WORK?		WORK PHONE #	
WORK ADDRESS				PREFERRED CONTACT #	
IF MINOR, PARENT(S) NAME(S)				PARENT CONTACT #	
EMERGENCY CONTACT (OTHER THAN YOUR FAMILY HOME)					
NAME		RELATIONSHIP		CONTACT #	
OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE			HOW DID YOU HEAR ABOUT OUR OFFICE?		

INSURANCE AND FINANCIAL INFORMATION

PLEASE PRESENT CARD TO RECEPTIONIST AT CHECK IN

PATIENT RELATIONSHIP TO SUBSCRIBER SELF SPOUSE DEPENDENT			SUBSCRIBER'S NAME – IF NOT PATIENT		
SUBSCRIBER'S SOCIAL SECURITY #		DATE OF BIRTH	SUBSCRIBER'S EMPLOYER		
INSURANCE COMPANY NAME		MAILING ADDRESS			
PHONE NUMBER	GROUP NUMBER		PATIENT ID #		

ASSIGNMENT & RELEASE

I hereby authorize Dr. Daniel Clader, DDS to submit insurance benefits on my behalf. I understand that insurance benefits will be paid directly to me.

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 policies.

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 _____