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 _____