CONFIDENTIAL INFORMATION QUESTIONNAIRE

Please Print

Patient Surname_____ **First name, Middle Initial**_____

Sex: M / F Date of Birth(D/M/Y)_____**Occupation**_____

Address_____ **Apt.**_____ **City**_____ **Province**_____

Postal Code_____ **E-Mail**_____ **Employer/school**_____

Marital Status: single❑ married❑ common law❑ divorced❑ under age 18❑

Home Phone #_____**Work Phone#**_____ **Cell / Other#**_____

*Spouse Surname*_____ *First name, Initial*_____

*Sex: M / F Date of Birth(D/M/Y)*_____*Occupation*_____

*Address*_____*Apt.*_____*City*_____ *Province*_____

*Postal Code*_____ *Employer/school*_____

*Home Phone #*_____ *Work Phone#*_____ *Other#*_____

Emergency Contact- Name_____ Relation_____

Home Phone#_____ Work Phone #_____ Other #_____

Other family member (s) at this office_____

Who can we thank for referring you to our office?_____

Insurance Coverage: Y / N Insurance Company_____

Subscriber Name_____ **Relationship to patient**_____

Subscriber Date of Birth (D/M/Y)_____**Policy #**_____**ID#**_____

*If Secondary Insurance exists: Insurance Company*_____

*Subscriber Name*_____ *Relationship to patient*_____

*Subscriber Date of Birth (D/M/Y)*_____*Policy #*_____ *ID #*_____

I authorize release, to my dental benefits plan administrator and CDA, information contained in claims submitted electronically. This authorization shall continue in effect until the Undersigned revokes the same.

_____ _____

Signature of patient, parent or guardian Date

In consideration of the services rendered to me by this dental office I am obligated to pay said office in accordance to its credit terms and policy. I consent to the taking of radiographs and photographs before, during, and after treatment and to the use of same by doctor in consultations and presentations.

Signature_____Date_____