DEL MAR DENTAL STUDIO

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Cosmetic Restorative Dentistry

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S LEGAL NAME: LAST, FIRST, MI				**DATE OF BIRTH**	**SEX**	**SSN(US)/SIN(CAN)**	
PREFERRED TO BE CALLED:		**HOME PHONE #**		**CELL PHONE #**			
PATIENT'S ADDRESS: STREET	APT/UNIT #	CITY	STATE	ZIP CODE	**EMAIL**		
MARITAL STATUS: ☐ S ☐ M ☐ W ☐ D ☐ UNDER AGE 18	**PATIENT'S/GUARDIAN'S EMPLOYER**			**OCCUPATION**			
WORK ADDRESS: STREET	APT/UNIT #	CITY	STATE	ZIP CODE	**WORK PHONE #**		
SPOUSE'S NAME: LAST, FIRST, MI		**SPOUSE'S EMPLOYER**		**OCCUPATION**			
WORK ADDRESS: STREET	APT/UNIT #	CITY	STATE	ZIP CODE	**WORK PHONE #**		
OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE		**WHOM CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?**					

EMERGENCY CONTACT INFORMATION

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

NAME	**RELATIONSHIP**	
HOME PHONE #	**WORK PHONE #**	**CELL PHONE #**

REQUEST FOR CONFIDENTIAL COMMUNICATION

AS MY DENTAL CARE PROVIDER, YOU MAY DO THE FOLLOWING WITH MY PERMISSION:

	YES	NO		YES	NO
Contact me at home	☐	☐	Leave messages on my home voicemail	☐	☐
Contact me via cell phone	☐	☐	Leave messages on my cell phone voicemail	☐	☐
Contact me at work	☐	☐	Leave messages on my work voicemail	☐	☐
Contact me via e-mail	☐	☐			

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INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE? *(MARK 'YES' OR 'NO')*	INSURANCE COMPANY NAME:		
☐ YES ☐ NO	ID NUMBER	INSURANCE ADDRESS	INSURANCE PHONE #

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER	SUBSCRIBER'S BIRTHDAY	SSN(US)/SIN(CAN)
	☐ SELF ☐ SPOUSE ☐ DEPENDENT		

GROUP/PROGRAM #	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER'S ADDRESS

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTHCARE WITH:

	YES	NO	OTHERS (PLEASE PRINT)
Healthcare Providers	☐	☐	1.
Insurance Companies	☐	☐	2.

CONFIRMATIONS

DO YOU PREFER A CONFIRMATION PHONE CALL?

☐ NO, it is unnecessary ☐ YES, it is a helpful reminder

ASSIGNMENT & RELEASE

I hereby authorize (1) any available insurance benefits to be paid directly to my dentist, (2) the release of my dental health care information for any of my dental health care insurance claim, (3) the use of my dental records by my dentist in any professional manner that he/she determines, (4) the making of videotapes, photographs, and x-rays of my dental care treatment (collectively "My Images"), and (5) my dentist's use of My Images in scientific papers, demonstrations, and/or presentations without compensation to me. I agree that to the extent the cost of the dental care provided by my dentist is not covered by insurance, I am obligated to pay him/her such uninsured cost (the "Uninsured Costs") in accordance with his/her payment terms and policies. Finally, I certify that I have read or had read to me the contents of this form and understand the risks and limitations involved with the dental treatment that I am to receive.

PATIENT'S ACKNOWLEDGEMENT OF RECEIPT OF DENTAL MATERIALS FACT SHEET

☐ I have received or been offered a copy of Dental Materials Fact Sheet.

SIGNATURE – PATIENT/GUARDIAN	DATE
WITNESS SIGNATURE	DATE

If the above named Patient is a minor or unable to pay his/her Uninsured Costs, the undersigned agrees to guaranty the payment of such Uninsured Costs to the Patient's dentist in accordance with his/her payment terms and policies.

SIGNATURE – GUARANTOR OF PATIENT	DATE

END OF PATIENT REGISTRATION SHEET