

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S LEGAL NAME LAST FIRST MI				DATE OF BIRTH		SEX	SSN(US) / SIN(CAN)
PREFER TO BE CALLED				HOME PHONE #		CELL PHONE #	
PATIENT'S ADDRESS		STREET	APT#	CITY	STATE	ZIP/POSTAL CODE	E-MAIL
MARITAL STATUS		PATIENT'S / GUARDIAN'S EMPLOYER				OCCUPATION	
<input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> UNDER AGE 18							
WORK ADDRESS		STREET	APT#	CITY	STATE	ZIP/POSTAL CODE	WORK PHONE #
SPOUSE'S NAME		LAST	FIRST	MI	SPOUSE'S EMPLOYER		OCCUPATION
SPOUSE'S WORK ADDRESS		STREET	APT#	CITY	STATE	ZIP/POSTAL CODE	WORK PHONE #
OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE					HOW DID YOU HEAR ABOUT US OR WHO 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
Contact me at home	<input type="checkbox"/>	<input type="checkbox"/>
Contact me via cell phone	<input type="checkbox"/>	<input type="checkbox"/>
Contact me at work	<input type="checkbox"/>	<input type="checkbox"/>
Contact me via e-mail	<input type="checkbox"/>	<input type="checkbox"/>
Leave messages on my home voicemail	<input type="checkbox"/>	<input type="checkbox"/>
Leave messages on my cell phone voicemail	<input type="checkbox"/>	<input type="checkbox"/>
Leave messages on my work voicemail	<input type="checkbox"/>	<input type="checkbox"/>

HIPPA

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.
- The practice shall not lease or sell your private information.

OFFICE FAILED APPOINTMENT POLICY

When your appointment is made, a dedicated chair and time slot is reserved just for you, your materials are ordered, and we make special arrangements to be ready for your visit. We ask that if you must reschedule your appointment that you please provide us with at least 2 days' notice. This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept.

A DEPOSIT* of \$150 will be required to reschedule after not showing up for a scheduled appointment.**

A DEPOSIT* of \$50 may be required to reschedule after canceling or rescheduling your appointment w/ out 2 days notice.**

*Deposits will be credited to your account when you attend your scheduled appointment.

**Repeated cancellations or missed appointments will result in the loss of future appointment privileges.

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE		INSURANCE COMPANY NAME		INSURANCE ADDRESS		INSURANCE PHONE	
<input type="checkbox"/> YES <input type="checkbox"/> NO							
SUBSCRIBER'S NAME		PATIENT'S RELATIONSHIP TO SUBSCRIBER		SUBSCRIBER'S BIRTHDAY		SSN(US) / SIN(CAN)	
		<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT					
GROUP/POLICY #:		EMPLOYER (IF DIFFERENT FROM ABOVE)		EMPLOYER'S ADDRESS			
MEMBER/PROGRAM #:							
SECONDARY COVERAGE		INSURANCE COMPANY NAME		INSURANCE ADDRESS		INSURANCE PHONE	
<input type="checkbox"/> YES <input type="checkbox"/> NO							
SUBSCRIBER'S NAME		PATIENT'S RELATIONSHIP TO SUBSCRIBER		SUBSCRIBER'S BIRTHDAY		SSN(US) / SIN(CA)	
		<input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE <input type="checkbox"/> DEPENDENT					
GROUP/POLICY #:		EMPLOYER (IF DIFFERENT FROM ABOVE)		EMPLOYER'S ADDRESS			
MEMBER/PROGRAM#:							

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTHCARE WITH

	YES	NO	OTHERS (PLEASE PRINT)
Health Care Providers	<input type="checkbox"/>	<input type="checkbox"/>	1.
Insurance Companies	<input type="checkbox"/>	<input type="checkbox"/>	2.

CONFIRMATIONS



DO YOU PREFER A CONFIRMATION CALL/TEXT

☐ 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. (6) I have read and agree with HIPPA terms above. (7) 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.

SIGNATURE - PATIENT / GUARDIAN	DATE
WITNESS SIGNATURE	DATE
If the above named Patient is a minor or unable to pay the 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