CONFIDENTIAL INFORMATION QUESTIONNAIRE

Please Print

PATIENT'S NAME LAST FIRST MIDDLE	DATE OF BIRTH	SEX	SOCIAL SECURITY #

PATIENT'S ADDRESS STREET APT# CITY STATE ZIP	HOME PHONE

MARITAL STATUS ☐ M ☐ S ☐ D ☐ W ☐ UNDER AGE 18	PATIENT'S/GUARDIAN'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET CITY STATE ZIP	WORK PHONE	OK TO CALL WORK ☐ YES ☐ NO

SPOUSE'S NAME LAST FIRST MIDDLE	SPOUSE'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET CITY STATE ZIP	WORK PHONE	OK TO CALL WORK ☐ YES ☐ NO

PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME) NAME RELATIONSHIP WORK # HOME #

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE:	EMAIL ADDRESS:	CELL PHONE:

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE ☐ YES ☐ NO	INSURANCE COMPANY NAME INSURANCE ADDRESS	INSURANCE PHONE

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S DOB	SUBSCRIBER'S ID #

GROUP NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER ADDRESS

SECONDARY COVERAGE ☐ YES ☐ NO	INSURANCE COMPANY NAME INSURANCE ADDRESS	INSURANCE PHONE

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ DEPENDENT	SUBSCRIBER'S DOB	SUBSCRIBER'S ID #

GROUP NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER ADDRESS

ASSIGNMENT & RELEASE:

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 policy. I understand that where appropriate, credit bureau reports may be obtained.

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balances due and authorize the dentist to release any information for this claim. I authorize that my records may be used by the doctor if he so determines.

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 (Parent's signature if minor)_____ Date_____

Charles E. Harding, D.M.D. 4955 Route 873, PO Box 266, Schnecksville, PA 18078
610-799-0600 • Fax 610-799-0602 • extraordinarysmiles.net