Confidential Information Questionnaire

Patient's Legal Name Last	First	MI	Date of Birth	Sex	SSN

Home Phone #	Cell Phone #	Work Phone #	Best time to call

Patient's Address Street	Apt #	City	State	Zip/Postal Code	Email

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Partnered ☐ Divorced ☐ Minor	Patient's / Guardian's Employer	Occupation

Work Address Street	City	State	Zip/Postal Code

Insurance Policy Holder Name Last First MI Mark if same as patient ☐	Policy Holder Employer	Occupation

Policy Holder's Work Address Street	City	State	Zip/Postal Code	Work Phone #

Other Family Members That Are Patients Here	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	☐	☐
Contact me via cell phone	☐	☐
Contact me at work	☐	☐
Contact me via email	☐	☐
Leave messages on my home voicemail / answering machine	☐	☐
Leave messages on my cell phone voicemail	☐	☐
Leave messages on my work voicemail / answering machine	☐	☐