all smiles.
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CONFIDENTIAL QUESTIONNAIRE

PATIENT'S NAME: LAST FIRST MIDDLE

DATE OF BIRTH GENDER: M F SOCIAL SECURITY #

PATIENT'S ADDRESS: STREET APT# CITY STATE ZIP

EMAIL HOME PHONE CELL PHONE

MARITAL STATUS: MARRIED SINGLE 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 PHONE OK TO CALL WORK? YES NO

WORK ADDRESS: STREET CITY STATE ZIP

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

NAME RELATIONSHIP

HOME # WORK # CELL #

OTHER FAMILY MEMBERS WHO ARE PATIENTS HERE

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?

INSURANCE AND FINANCIAL INFORMATION

INSURANCE? YES NO INSURANCE COMPANY NAME

ADDRESS CITY STATE ZIP PHONE

SUBSCRIBER'S NAME PATIENT'S RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE DEPENDENT

SUBSCRIBER'S DATE OF BIRTH: SUBSCRIBER'S SSN: GROUP/PROGRAM NUMBER

EMPLOYER (IF DIFFERENT FROM ABOVE) EMPLOYER ADDRESS

SECONDARY INSURANCE? YES NO INSURANCE COMPANY NAME

ADDRESS CITY STATE ZIP PHONE

SUBSCRIBER'S NAME PATIENT'S RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE DEPENDENT

SUBSCRIBER'S DATE OF BIRTH: SUBSCRIBER'S SSN: GROUP/PROGRAM NUMBER

EMPLOYER (IF DIFFERENT FROM ABOVE) EMPLOYER ADDRESS

ASSIGNMENT & RELEASE:

I hereby authorize my insurance benefits to be paid directly to All Smiles. I am financially responsible for any balances due and authorize All Smiles to release any information for this claim. I authorize that my records can be used by All Smiles if it so determines.

In consideration of the services rendered to me by All Smiles, I am obligated to pay said office in accordance with its credit terms and policy.I consent to the making of videotapes, photographs, and x-rays before, during, and after treatment, and to the use of same by All Smiles 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 _____ DATE _____

NOTE: If remitting electronically via email or fax, patient will sign and date at first office visit.

EMAIL PRINT SAVE to disk CLEAR INFO