



CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S LEGAL NAME: LAST, FIRST, MI, PREFERRED PRONOUNS		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: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> W <input type="checkbox"/> D <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	Leave messages on my home voicemail	<input type="checkbox"/>	<input type="checkbox"/>
Contact me via cell phone	<input type="checkbox"/>	<input type="checkbox"/>	Leave messages on my cell phone voicemail	<input type="checkbox"/>	<input type="checkbox"/>
Contact me at work	<input type="checkbox"/>	<input type="checkbox"/>	Leave messages on my work voicemail	<input type="checkbox"/>	<input type="checkbox"/>
Contact me via e-mail	<input type="checkbox"/>	<input type="checkbox"/>			

INSURANCE AND FINANCIAL INFORMATION

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

RELEASE INFORMATION

YOU MAY DISCUSS MY HEALTHCARE WITH:		
	YES	NO
Healthcare Providers	<input type="checkbox"/>	<input type="checkbox"/>
Insurance Companies	<input type="checkbox"/>	<input type="checkbox"/>
	OTHERS (PLEASE PRINT)	
	1.	
	2.	

CONFIRMATIONS

DO YOU PREFER A CONFIRMATION PHONE CALL?	
<input type="checkbox"/> NO, it is unnecessary	<input type="checkbox"/> YES, it is a helpful reminder

ASSIGNMENT & RELEASE

I, the undersigned, understand that Del Mar Dental Studio is out of network with all insurance companies. This means I am fully responsible for paying all charges at the time of service, regardless of any insurance coverage. I understand that it is my responsibility to seek reimbursement from my insurance company, and I will work directly with them to collect any payments. As a courtesy, Del Mar Dental Studio will provide assistance by submitting the necessary paperwork to help facilitate my claim, but I acknowledge that this does not guarantee any payment or reimbursement from my insurance company. I authorize the release of any information necessary to submit claims and secure any potential reimbursement for services rendered. I assign any insurance benefits that may be paid to me directly for these services to Del Mar Dental Studio.

I, the undersigned, grant permission to Del Mar Dental Studio to take photographs and/or video recordings of me for documenting treatment. I understand that these images may be used for marketing purposes, including but not limited to social media, the practice's website, and other promotional materials. I acknowledge that I will not receive compensation for the use of these images. If I do not wish to have my images used for marketing, I will inform the practice in writing. All images will be used in accordance with HIPAA regulations to protect my privacy.

I understand that Del Mar Dental Studio may use secure voice documentation technology to assist with clinical documentation during my visit. Portions of my appointment may be audio recorded to help create accurate clinical notes. All audio recordings and related information are handled in accordance with HIPAA privacy and security requirements. De-identified information may be used to improve the documentation software and is not used for advertising or marketing purposes. Participation is optional, and I understand that I may decline or withdraw consent at any time, in which case my visit will be documented using traditional methods.

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