

# 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
<b>MARITAL STATUS</b> S   M   W   D UNDER AGE 18		PATIENT'S / GUARDIAN'S EMPLOYER			OCCUPATION	
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			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 via text
- Contact me via cell phone
- Contact me at work
- Contact me via e-mail
- Leave messages on my home voicemail
- Leave messages on my cell phone voicemail
- Leave messages on my work voicemail