ROCHESTER
DENTAL CLINIC

Patient focused, Family Friendly

Confidential Information Questionnaire

Patient's Legal Name Last First MI Date of Birth

Social Security Number (Last Four Digits) Gender M☐ F☐

Prefer to be called Home Phone # Work Phone# Cell Phone #

Patient's Address Street Apt # City State Zip Email

Marital Status S☐ M☐ W☐ D☐

Spouses Name and Employer_____

Other family members that are patients here_____

Who can we thank for referring you to our office?_____

Under 18☐

Parent/Guardian: _____
(Complete if patient is under 18 or on your insurance)

Insurance and Financial Information

Insurance Coverage Y☐ N☐

Insurance Company's Name Insurance Claims Address Insurance Phone Number

Subscriber's Name Patient's relationship to subscriber Self☐ Spouse☐ Dependant☐ Subscriber's birthday

Subscriber's SSN or Insurance ID # _____

Group / Program Number_____ Employer_____

Secondary Coverage Y☐ N☐

Insurance Company's Name _____ Insurance Claims Address _____ Insurance Phone Number _____

Subscriber's Name _____ Self ☐ Spouse ☐ Dependant ☐ Patient's relationship to subscriber _____ Subscriber's Birthday _____

Subscriber's SSN or Insurance ID # _____

Emergency Contact Information

Person we may contact in case of an emergency (other than your family home)

Name _____ Relationship _____

Home Phone Number _____ Work Phone Number _____ Cell Phone Number _____

Request for Confidential Communication

As my dental care provider, you may do the following with my permission

	Y	N
Contact me at home	☐	☐
Contact me via cell phone	☐	☐
Contact me at work	☐	☐
Contact me via text	☐	☐
Contact me via email	☐	☐

Assignment & Release

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balance due and authorize the dentists to release any information for claims. I authorize that my records can be used by the doctor if they so determine. In consideration of the services rendered to me by the dental office, I am obligated to pay said office in accordance with its credit terms and policy.

I consent to making of videotapes, photographs, and x-rays before, during, and after treatment to be used by the doctor in scientific papers, demonstrations, presentations, laboratory communication and or social media which includes but is not limited to their Facebook page. These videos will not be use for other commercial purposes. These images will become property of my dental record.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Patient Signature_____Date_____Witness_____Date_____

Parent/Guardian Signature (patient under 18)_____Date_____