Pediatric Confidential Information Questionnaire

Patient's Legal Name Last First MI Date of Birth Social Security # (Last Four Digits)

Person responsible for account Home Phone # Work Phone# Cell Phone #

Patient's Address Street Apt # City State Zip Email

Insurance and Financial Information

Patient's relationship to subscriber Subscriber's Name Subscriber's birthday

Subscriber's SSN or Insurance ID # Group/Program # Employer

Insurance Coverage? Yes ☐ No ☐ Insurance Company's Name Insurance Address Insurance Phone Number

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

	Yes	No		Yes	No
Contact me at home	☐	☐	Contact me via text	☐	☐
Contact me via cell phone	☐	☐	Contact me via email	☐	☐
Contact me at work	☐	☐			

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.

Parent/Guardian Signature (patient under 18)_____**Date**_____

_____ _____ _____

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

_____ Self ☐ Spouse ☐ Dependant ☐ _____

Subscriber's Name | 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

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Patient Signature_____Date_____Witness_____Date_____

Parent/Guardian Signature (patient under 18)_____Date_____