IMPLANT DENTISTRY
NORTHWEST

PLEASE PRINT LEGIBLY

5519 Valley Ave E., Tacoma, WA 98424
(253) 922-5519

Confidential Information Questionnaire

PATIENT'S LEGAL NAME (LAST, FIRST, MI)	DOB	GENDER IDENTITY
PREFER TO BE CALLED	PHONE #	PREFERRED PRONOUNS
PATIENT'S HOME ADDRESS	CITY/STATE	ZIP
MARITAL STATUS S ☐ M ☐ D ☐ W ☐	EMAIL	
PATIENT'S/GUARDIAN'S EMPLOYER	OCCUPATION	WORK PHONE #
WORK ADDRESS	CITY/STATE	ZIP
SPOUSE'S LEGAL NAME (LAST, FIRST, MI	SPOUSE'S EMPLOYER	WORK PHONE #
OTHER FAMILY MEMBERS WHO ARE PATIENTS AT OUR PRACTICE	HOW DID YOU HEAR OF OUR PRACTICE?	

Emergency Contact Information

NAME	RELATIONSHIP
PHONE #	WORK PHONE #
PHYSICIAN NAME	PHYSICIAN PHONE #

Request for Confidential Communication

AS MY DENTAL CARE PROVIDER, YOU MAY DO THE FOLLOWING WITH MY PERMISSION:

	YES	NO		YES	NO
CONTACT ME BY PERSONAL PHONE	☐	☐	LEAVE MESSAGES ON MY PERSONAL VOICEMAIL	☐	☐
CONTACT ME VIA EMAIL	☐	☐	SEND TEXT MESSAGES TO MY PHONE	☐	☐
CONTACT ME AT MY WORK PHONE	☐	☐	LEAVE MESSAGES ON MY WORK VOICEMAIL	☐	☐

Insurance Information

DENTAL INSURANCE? YES ☐ NO ☐	DENTAL INSURANCE COMPANY NAME	DENTAL INSURANCE ADDRESS	DENTAL INSURANCE PHONE #
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF SPOUSE DEPENDENT	SUBSCRIBER'S DOB	SUBSCRIBER'S GROUP # & ID #
SECONDARY DENTAL INSURANCE? YES ☐ NO ☐	INSURANCE COMPANY NAME	INSURANCE ADDRESS	INSURANCE PHONE #
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF SPOUSE DEPENDENT	SUBSCRIBER'S DOB	SUBSCRIBER'S GROUP # & ID #
MEDICAL INSURANCE? YES ☐ NO ☐	MEDICAL INSURANCE COMPANY NAME	MEDICAL INSURANCE ADDRESS	MEDICAL INSURANCE PHONE #
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF SPOUSE DEPENDENT	SUBSCRIBER'S DOB	SUBSCRIBER'S GROUP # & ID #

Assignment & Release

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for any insurance claim. In consideration of the services rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy. I authorize that my records can be used by the doctor if he/she so determines. I consent to the making of videos, photographs, and radiographs before, during, and after treatment, and to the use of same by the doctor in scientific papers, demonstrations, and/or presentations.

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 – PATIENT/GUARDIAN	DATE	SIGNATURE – WITNESS	DATE