PLEASE PRINT

CONFID	ENTIA	AL IN	FORMA	TION QL	JESTI	ONNAIRE	
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# CIT	Y STATI	E-MAIL			
MARITAL STATUS S M W D UNDER AGE 18	PATIENT'S / GUARDIAN'S EMPLOYER				OCCUPATION		
WORK ADDRESS	STREET	APT# CITY	Y STATE	E ZIP/POSTAL CODE	WORK PHON	E #	
SPOUSE'S NAME	LAST	FIRST	MI	SPOUSE'S EMPLOYER		OCCUPATION	
SPOUSE'S WORK ADDRESS	STREET	APT# CIT	Y STAT	E ZIP/POSTAL CODE	WORK PHON	E #	
OTHER FAMILY MEMBERS T	HAT ARE PATIEN	NTS HERE		WHO CAN WE THANK	K FOR REFERRIN	NG 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 at home 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 © 2018 Kois Center, LLC

PLEASE PRINT							
INSURANCE AND FINANCIAL INFORMATION							
INSURANCE INSURANCE COMP.	ANY NAME	INSURANCE ADDRESS	INSURANCE ADDRESS				
YES NO							
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER SUBSCRIBER'		SUBSCRIBER'S BIRTHDAY	SSN(US) / SIN(CAN)			
	SELF SPOUSE DEPENDENT						
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)		EMPLOYER'S ADDRESS				
SECONDARY COVERAGE	ANY NAME	INSURANCE ADDRESS		INSURANCE PHONE			
SUBSCRIBER'S NAME	PATIENT'S RELAT	IONSHIP TO SUBSCRIBER	SUBSCRIBER'S BIRTHDAY	SSN(US) / SIN(CA)			
	SELF SPO	OUSE 🗌 DEPENDENT					
GROUP / PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)		EMPLOYER'S ADDRESS				
RELEASE INFORMATION							
YOU MAY DISCUSS MY HEALTHCARE WITH							
	YES NO	OTHERS (PLEASE PRINT)					
Health Care Providers Insurance Companies		1.					
		2.					

CONFIRMATIONS

DO YOU PREFER A CONFIRMATION CALL

No, it is unnecessary

Yes, it is a helpful reminder

ASSIGNMENT & RELEASE

I hereby authorize (1) any available insurance benefits to be paid directly to my dentist, (2) the release of my dental health care information for (4) the making of videotapes, photographs, and x-rays of my dental records by my dentist in any professional manner that he/she determines, (4) the making of videotapes, photographs, and x-rays of my dental records by my dentist in any professional manner that he/she determines, (4) the making of videotapes, photographs, and x-rays of my dental care treatment (collectively "My Images"), and (5) my dentist' use of My Images in scientific papers, demonstrations and/or presentations without compensation to me. I agree that to the extent the cost of the dental care provided by my dentist is not covered by insurance, I am obligated to pay him/her such uninsured cost (the "Uninsured Costs") in accordance with his/her payment terms and policies. Finally, I certify that I have read or had read to me the contents of this form and understand the risks and limitations involved with the dental treatment that I am to receive.

SIGNATURE - PATIENT / GUARDIAN	DATE	
WITNESS SIGNATURE	DATE	
If the above named Patient is a minor or unable to pay the 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	