CONFIDENTIAL INFORMATION QUESTIONAIRE

Patient's Name Last First MI Mr. Mrs. Ms. Dr.	I Prefer to be called	Date of Birth	Age

Social Security#	If Child: Parent/Guardian's Name	Parent/Guardian's DOB	Parent/Guardians SS#	Patient's Marital Status M S D W Under age 18

Patient's Address Street Apt# City State Zip	Home Phone

Email	Cell Phone	Work Phone ext	OK TO CALL WORK YES NO EMERG.ONLY

Patient's/Guardian's Employer	Occupation

Work Address Street City State Zip

Spouse's Name Last First MI Mr. Mrs. Ms. Dr.	Spouse's Employer	Spouse's Occupation

Spouse's Work Address Street City State Zip	Cell Phone	Work Phone	OK TO CALL WORK YES NO

PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)				
Name	Relationship	Home#	Work#	Cell#

Other family members that are patients here	Whom may we thank for referring you to our office

INSURANCE AND FINANCIAL INFORMATION

Dental Insurance Coverage YES NO	INSURANCE COMPANY NAME ADDRESS PHONE

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF SPOUSE DEPENDENT OTHER _____	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SS# OR ID#

GROUP/PROGRAM NUMBER	EMPLOYER	EMPLOYER ADDRESS

Secondary Dental Insurance Coverage YES NO	INSURANCE COMPANY NAME ADDRESS PHONE

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF SPOUSE DEPENDENT OTHER _____	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SS# OR ID#

GROUP/PROGRAM NUMBER	EMPLOYER	EMPLOYER ADDRESS

ASSIGNMENT & RELEASE:

I hereby authorize my insurance benefits to be paid directly to Dr. Brian D. Valle, P.A. I am financially responsible for any balances due and authorize Dr. Brian D. Valle, P.A. to release any information for this claim. I authorize that my records can be used by the doctor if he so determines.

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

Signature of Patient/Guardian _____ Date _____

SUBMIT