# WELCOME TO DENTISTRY ON DANFORTH

# CONFIDENTIAL INFORMATION QUESTIONNAIRE

Patient is an: ☐ Adult ☐ Child ☐ Adult Under Guardianship Guardian's Name: _____

☐ DR. ☐ MR. ☐ MRS. ☐ MS. ☐ MISS

| PATIENT'S NAME LAST FIRST MIDDLE | PREFERRED NAME | DATE OF BIRTH DD/MM/YYYY | SEX |
|---|---|---|---|
| | | | |

| PATIENT'S ADDRESS STREET APT# CITY PROV. POSTAL CODE | HOME PHONE |
|---|---|
| | |

| WORK PHONE | PAGER | CELLULAR | EMAIL | OK TO CALL WORK ☐ YES ☐ NO |
|---|---|---|---|---|
| | | | | |

| MARITAL STATUS ☐M ☐S ☐D ☐ UNDER 18 | PATIENT'S/GUARDIAN'S EMPLOYER | OCCUPATION |
|---|---|---|
| | | |

REASON FOR TODAY'S VISIT? ☐ EXAMINATION ☐ EMERGENCY ☐ OTHER _____

IS THERE A DENTAL PROBLEM YOU WOULD LIKE TREATED IMMEDIATELY?_____

PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME RELATIONSHIP WORK #(ext.) HOME #

| OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE | WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE? |
|---|---|
| | |

# INSURANCE AND FINANCIAL INFORMATION

Person Responsible for account: ☐ Self ☐Spouse ☐ Partner ☐ Other (Please complete all information if different than above)

NAME HOME # WORK#(ext.) EMPLOYER

| INSURANCE COVERAGE ☐YES ☐NO | PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ PARTNER ☐ DEPENDENT | SUBCRIBER'S NAME | DATE OF BIRTH DD/MM/YYYY |
|---|---|---|---|
| | | | |

| INSURANCE COMPANY NAME | SUBSCRIBER'S SIN# |
|---|---|
| | |

| EMPLOYER | GROUP/POLICY # | DIVISION # | CERTIFICATE/ ID # |
|---|---|---|---|
| | | | |

| SECONDARY INSURANCE ☐YES ☐NO | PATIENT'S RELATIONSHIP TO SUBSCRIBER ☐ SELF ☐ SPOUSE ☐ PARTNER ☐ DEPENDENT | SUBCRIBER'S NAME | DATE OF BIRTH DD/MM/YYYY |
|---|---|---|---|
| | | | |

| INSURANCE COMPANY NAME | SUBSCRIBER'S SIN# |
|---|---|
| | |

| EMPLOYER | GROUP/POLICY # | DIVISION # | CERTIFICATE/ ID # |
|---|---|---|---|
| | | | |

**METHOD OF PAYMENT ☐ CASH ☐ DIRECT PAYMENT ☐ CREDIT CARD ☐ OTHER _____**

**RELEASE**

I am financially responsible for any balances due on the day of treatment, and authorize the dentist to release any information for insurance claims to the insurance company on my behalf. In consideration of the services rendered to me by this office I am obligated to pay said office in accordance with its credit terms and policy. I consent to the taking of photographs and x-rays before, during, and after treatment, and to the use of same by the doctor in scientific papers or demonstrations. 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_____Date_____

(Patient or Guardian)