CONFIDENTIAL INFORMATION QUESTIONNAIRE

Patient Name ______________________ Date of Birth __________ Sex _____

Prefer to be called ______________________ Marital Status ☐ S ☐ M ☐ W ☐ D ☐ Partner

Driver's License # ______________________ SSN ______________________

Home Phone ______________________ Cell Phone ______________________

Address ______________________

City ______________________ State __________ Zip __________

Email ______________________

Patient/Guardian Employer ______________________ Occupation ______________________

Work Address ______________________ City __________ State _____ Zip __________ Work Phone __________

Spouse's Name ______________________ Spouse's Employer ______________________ Occupation ______________________

Spouse's Work Address ______________________ City __________ State _____ Zip __________ Work Phone __________

Other family members that are patients ______________________

Who can we thank for referring you ______________________

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 to contact me and confirm my appointments:

Contact me via phone........ ☐ Y ☐ N
Contact me via text message........ ☐ Y ☐ N
Phone contact preference........ ☐ Cell ☐ Home
Contact me via e-mail........ ☐ Y ☐ N

INSURANCE AND FINANCIAL INFORMATION

Insurance coverage ☐ Y ☐ N Insurance Company Name __________ Address __________ Phone __________

Subscriber's Name __________ Patient's relationship to subscriber __________ Subscriber D.O.B. __________ SSN __________

Group/Program Number __________ Employer (if different from above) __________ Employer's Address __________

Secondary Insurance ☐ Y ☐ N Insurance Company Name __________ Address __________ Phone __________

Subscriber's Name __________ Patient's relationship to subscriber __________ Subscriber D.O.B. __________ SSN __________

Group/Program Number __________ Employer (if different from above) __________ Employer's Address __________

RELEASE INFORMATION

You may discuss my healthcare with: Healthcare Providers ☐ Y ☐ N Insurance Companies ☐ Y ☐ N

Others (please print) ______________________

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 any of my dental health care insurance claim, (3) the use 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's use of My Images in scientific papers, demonstrations and/or presentations without compensation to me. I agree that to the extent of the cost of the dental care provided by my dentist is not covered by insurance, I am obligated to pay him/her such unisured 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 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 __________

John W. Mashni, D.D.S., P.C. | James M. Mashni, D.D.S. | Jason D. Mashni, D.D.S.
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