# CONFIDENTIAL INFORMATION QUESTIONNAIRE

| 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# CITY STATE ZIP/POSTAL CODE | E-MAIL |
|---|---|
| | |

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

| WORK ADDRESS STREET APT# CITY STATE ZIP/POSTAL CODE | WORK PHONE # |
|---|---|
| | |

| SPOUSE'S NAME LAST, FIRST MI | SPOUSE'S EMPLOYER | OCCUPATION |
|---|---|---|
| | | |

| SPOUSE'S WORK ADDRESS STREET APT# CITY STATE ZIP/POSTAL CODE | WORK PHONE # |
|---|---|
| | |

| OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE | WHO CAN WE THANK FOR REFERRING 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 / answering machine | ☐ | ☐ |
| Leave messages on my cell phone voicemail | ☐ | ☐ |
| Leave messages on my work voicemail / answering machine | ☐ | ☐ |