Dental Solutions
Family & Cosmetic Dentistry

CONFIDENTIAL INFORMATION QUESTIONNAIRE

PATIENT'S NAME LAST FIRST MIDDLE				DATE OF BIRTH	SEX	SOCIAL SECURITY #
PATIENT'S ADDRESS STREET APT # CITY STATE ZIP					EMAIL	
HOME PHONE		WORK PHONE			CELL PHONE	
MARITAL STATUS ❑ M ❑ S ❑ D ❑ W ❑ UNDER AGE 18		PATIENT'S/GUARDIAN'S EMPLOYER			OCCUPATION	
WORK ADDRESS STREET CITY STATE ZIP						OK TO CALL WORK ❑ YES ❑ NO
SPOUSE'S NAME LAST FIRST MIDDLE			SPOUSE'S EMPLOYER		OCCUPATION	
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			HOW DID YOU HEAR ABOUT OUR OFFICE			

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE ❑ YES ❑ NO	INSURANCE COMPANY NAME		ADDRESS	PHONE
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ❑ SELF ❑ SPOUSE ❑ DEPENDENT	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN	
GROUP/PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER ADDRESS		
SECONDARY COVERAGE ❑ YES ❑ NO	INSURANCE COMPANY NAME		ADDRESS	PHONE
SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER ❑ SELF ❑ SPOUSE ❑ DEPENDENT	SUBSCRIBER'S DATE OF BIRTH	SUBSCRIBER'S SSN	
GROUP/PROGRAM NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)	EMPLOYER ADDRESS		

ASSIGNMENT & RELEASE

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 understand that payment is due in full at each appointment at the time of service. We are a Care Credit provider and can accept payment through that account as well.

I understand that Dr. Elahe Wissinger does not participate in any PPO dental insurance programs, however if you have dental insurance, we are happy to bill your dental insurance for you. Your dental insurance will reimburse you directly. I authorize release of my dental records to be used by the doctor if required by said dental insurance company for purposes of reimbursement.

We ask for a 48 hour business day notice Monday - Thursday for all appointment changes or cancelled appointments, so that we are able to offer that reserved time to another patient. A $50.00 per hour fee will be charged if proper notice during business hours is not given.

We are now requesting a credit card to be kept on file to be charged only in accordance with our cancellation policy. We accept Visa, MasterCard and American Express.

Card #_____Exp._____Security Code_____

I consent to the making of videotapes, photographs and x-rays before, during and after treatment, and to the use of same by doctor in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do agree to its terms.

Signature_____Date_____

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