Ladner Dental Clinic **WELCOME TO OUR OFFICE**

CONFIDENTIAL INFORMATION QUESTIONNAIRE

Patient's Name _____ Birthday _____
last first initial month / day / year

Address _____ Home Phone _____

City/Province _____ Postal Code _____ Cell Phone _____

Employer _____ Business Phone _____ Email _____

Spouse's Name _____ Spouse's Phone _____

Who may we contact in case of an emergency if we can't reach your spouse? _____
Do you have other family members who are patients here, please list. _____
Who may we thank for referring you to our office? _____

INSURANCE AND FINANCIAL INFORMATION

Payment of your uninsured portion is <u>due</u> at time of service. The office will assist you with the claim to your insurance carrier for 30 days. We do accept VISA, MasterCard and Debit.

<u>PRIMARY DENTAL INSURANCE</u>

Name of Insured Date of Birth

_____
Employer

_____
Insurance Carrier Group Policy Number

_____
ID/Certificate Number Division

_____
Coverage Percentage

Basic/Prevent _____ Major _____ Ortho _____

<u>SECONDARY DENTAL INSURANCE</u>

Name of Insured Date of Birth

_____
Employer

_____
Insurance Carrier Group Policy Number

_____
ID/Certificate Number Division

_____
Coverage Percentage

Basic/Prevent _____ Major _____ Ortho _____

Note: A charge will be applied for broken appointments unless <u>2 business days</u> notice is given.
Please note: Payment in full is <u>due</u> at time of treatment.

ASSIGNMENT AND RELEASE

I hereby authorize that my insurance benefits be paid directly to the dentist. I accept financial responsibility for any balance due. I authorize the dentists to release any information for these claims and to submit them electronically. I consent to the taking of videos, photos, and x-rays before, during and after treatment and to the use of these items as well as my records by the dentist for educational purposes, scientific papers or presentations.

I certify that I have read the contents of this form and do realize the risks and limitations involved.

Signature _____ Date _____