

# CONFIDENTIAL PATIENT INFORMATION



PATIENT'S NAME Last                      First                      Middle			DATE OF BIRTH (MM/DD/YY)	Gender <input type="checkbox"/> F <input type="checkbox"/> M
PATIENT'S ADDRESS		Home Phone #	Cell phone #	Work Phone #
		By which way do you prefer to communicate with us? (Check more than one choices if necessary)		
		<input type="checkbox"/> Home #	<input type="checkbox"/> Cell #	<input type="checkbox"/> Work # <input type="checkbox"/> Text <input type="checkbox"/> Email
MARITAL STATUS	PATIENT'S/GUARDIAN'S EMPLOYER		OCCUPATION	

EMAIL ADDRESS (Your email address will be in confidence and only used for office communication with you)

SPOUSE'S NAME Last                      First                      Middle			SPOUSE'S EMPLOYER	OCCUPATION
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**PERSON WE CAN CONTACT IN CASE OF EMERGENCY (OTHER THAN YOUR FAMILY HOME)**

NAME:	RELATIONSHIP:	WORK NO.	HOME NO.
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**HOW DID YOU HEAR ABOUT US?**

FRIENDS/FAMILY (Please Name \_\_\_\_\_ )  
  DIRECT MAIL/FLYERS  
  WEBSITE/INTERNET  
  PTBO Examiner  
  PTBO This Week  
 DRIVE-BY  
  Yellowpages  
  Canpages  
  PTBO This Week Goldbook  
  OTHERS ( \_\_\_\_\_ )

# INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO	INSURANCE COMPANY NAME	INSURANCE ADDRESS	
SUBSCRIBER'S NAME (If different from above)	PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE/CommonLaw <input type="checkbox"/> DEPENDENT	SUBSCRIBER D.O.B (If different from above)	SUBSCRIBER'S S.I.N. (Optional)
Group Number AND ID Number	EMPLOYER	EMPLOYER'S ADDRESS	
SECONDARY INSURANCE COVERAGE <input type="checkbox"/> YES <input type="checkbox"/> NO	2 <sup>nd</sup> INSURANCE COMPANY NAME	2 <sup>nd</sup> INSURANCE ADDRESS	
SUBSCRIBER'S NAME (If different from above)	PATIENT'S RELATIONSHIP TO SUBSCRIBER <input type="checkbox"/> SELF <input type="checkbox"/> SPOUSE/CommonLaw <input type="checkbox"/> DEPENDENT	SUBSCRIBER D.O.B (If different from above)	SUBSCRIBER'S S.I.N. (Optional)
GROUP/PROGRAM NUMBER	EMPLOYER (If different from above)	EMPLOYER'S ADDRESS	

I authorize Dr. Rhee to submit any necessary pre-determinations inquiring further information about my dental benefits for recommended treatments.    Yes \_\_\_\_\_    No \_\_\_\_\_

**GENERAL RELEASE**

I, the undersigned, certify that I have provided an accurate and complete personal and medical-dental history and have not knowingly omitted any information. I have had the opportunity to ask any questions and receive answers to any questions regarding my medical-dental history. I realize that the dentist is a general practitioner who offers many specialized treatments to patients. Should there be any change in my health status in the future, I will advise this dental office.

I authorize the dentist to perform diagnostic procedures as may be required to determine necessary treatment. I understand that information provided from or to my doctor or another health care provider may be necessary.

I consent to the responsibility for payment of the dental services for myself and my dependents is mine solely and I assume responsibility for fees associated with these services. I understand this office requires **24 hour** notification to avoid any minimum charges.

Patient's or Guardian's Signature \_\_\_\_\_

Date \_\_\_\_\_