HUMBERLAND DENTAL

Confidential Information Questionaire ***Please print*** **Medical Alert** ☐

Patient's Name

Last	**First**	**Middle Initial**	**Preferred Name**

Date of Birth	**Gender**	**Marital Status**
Month Day Year	☐ Male ☐ Female	M☐ S☐ D☐ W☐ Under Age 18☐

Contact Information:

Home Address

Street	City	Prov.	Postal Code

Contact Info

Residence Phone	Cell Phone	Email Address

Dental Insurance Provider	Policy #	Member#

Patient/Guardian's Employer

Business Name

Family Information:

Spouse's Name

Last	First	Middle Initial	Date of Birth (MM/DD/YYYY)

Spouse's Employer

Business Name	Dental Insurance Provide	Policy #	Member #

Emergency Information:

Person we can contact in case of an emergency **other than your spouse**

Name	Relationship	Cell #

Other Family Members that are patients here:

Who can we thank for referring you to our office:

In consideration of the services rendered to me by this dental office I am obligated in accordance with its credit terms and policy.
I consent to the taking of photographs and x-rays before, during and after treatment, and to the use of same by the doctor in scientific papers or demonstrations.
I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

Signature: *I understand that completing this field acts as the equivalent to my valid physical signature* **Date:**