Jill Shelton Wagers D.M.D.
FAMILY DENTISTRY

CONFIDENTIAL INFORMATION QUESTIONNAIRE

Welcome! *Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. To help us meet all of your dental healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.*

Please Print

PATIENT'S NAME LAST	FIRST	MIDDLE	DATE OF BIRTH	SEX	SOCIAL SECURITY #	
PATIENT'S ADDRESS STREET	APT #	CITY	STATE	ZIP	HOME PHONE	
RESPONSIBLE PARTY			RELATIONSHIP TO PATIENT			
DRIVER'S LICENSE # OF RESPONSIBLE PARTY			STATE LICENSE ISSUED IN			
MARITAL STATUS ☐M ☐S ☐D ☐W ☐ UNDER AGE 18	PATIENT'S/GUARDIAN'S EMPLOYER			OCCUPATION		
WORK ADDRESS STREET	CITY	STATE	ZIP	WORK PHONE	OK TO CALL WORK ☐YES ☐NO	
SPOUSE'S NAME LAST	FIRST	MIDDLE	SPOUSE'S EMPLOYER		OCCUPATION	
WORK ADDRESS STREET	CITY	STATE	ZIP	WORK PHONE	OK TO CALL WORK ☐YES ☐NO	
IF STUDENT, NAME OF SCHOOL/COLLEGE	CITY	STATE	☐ FULL TIME	☐ PART TIME		
PERSON WE CAN CONTACT IN CASE OF AN EMERGENCY (OTHER THAN YOUR FAMILY HOME) NAME WORK #	HOME #		RELATIONSHIP			
OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE			WHOM MAY WE THANK FOR REFERRING YOU TO OUR OFFICE			
INSURANCE COVERAGE ☐YES ☐NO	INSURANCE COMPANY NAME INSURANCE ADDRESS				INSURANCE PHONE	
NAME OF INSURED ☐ SELF ☐ SPOUSE ☐ DEPENDENT	RELATIONSHIP TO INSURED	INSURED DATE OF BIRTH		INSURED S.S.N.		
GROUP/POLICY NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)		EMPLOYER ADDRESS			
SECONDARY COVERAGE ☐YES ☐NO	INSURANCE COMPANY NAME INSURANCE ADDRESS				INSURANCE PHONE	
NAME OF INSURED ☐ SELF ☐ SPOUSE ☐ DEPENDENT	RELATIONSHIP TO INSURED	INSURED DATE OF BIRTH		INSURED S.S.N.		
GROUP/POLICY NUMBER	EMPLOYER (IF DIFFERENT FROM ABOVE)		EMPLOYER ADDRESS			

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge.
I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services ndered.
i authorize the use of this signature on all insurance submissions. I authorize the dentist to release all necessary information to secure e payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

gnature_____ Date _____ Dental Personnel Initials: _____