COASTAL CITY
DUNSMUIR DENTAL CENTRE

CONFIDENTIAL INFORMATION QUESTIONAIRE

PATIENT'S LEGAL NAME	DATE OF BIRTH	SEX

PREFERRED NAME	CELL PHONE #	HOME PHONE #

PATIENT'S ADDRESS STREET CITY PROVINCE POSTAL CODE	EMAIL

INSURANCE AND FINANCIAN INFORMATION

PRIMARY INSURANCE COVERAGE	INSURANCE COMPANY NAME
☐ YES ☐ NO	

SUBSCRIBER'S NAME	PATIENT RELATIONSHIP TO SUBSCRIBER	SUBSCRIBER'S BIRTHDAY (DD/MM/YY)
	○ Self ○ Spouse ○ Child ○ Common Law	

ID / CERTIFICATE NUMBER	POLICY / PLAN/ GROUP NUMBER

SECONDARY INSURANCE COVERAGE	INSURANCE COMPANY NAME
☐ YES ☐ NO	

SUBSCRIBER'S NAME	PATIENT RELATIONSHIP TO SUBSCRIBER	SUBSCRIBER'S BIRTHDAY (DD/MM/YY)
	○ Self ○ Spouse ○ Child ○ Common Law	

ID / CERTIFICATE NUMBER	POLICY / PLAN/ GROUP NUMBER

EMERGENCY CONTACT INFORMATION

PERSON WE MAY CONTACT IN CASE OF AN EMERGENCY

NAME	RELATIONSHIP

CELL PHONE #	OTHER PHONE #

REMINDER PREFERENCE

☐ Email ☐ Text Messages (SMS) ☐ Phone Call

ASSIGNMENT & RELEASE

I hereby authorize (1) any available insurance benefit to be paid directly to my dentist, (2) the release of my dental health care information for any of my dental health care insurance claim, (3) the use of my dental records by my dentist in any professional manner that he/she determines, (4) the making of videotapes, photographs, and x-rays of my dental care treatment (collectively "My Images"), and (5) my dentist's use of My Images in scientific papers, demonstrations and/or presentations without compensation to me. I agree that to the extent the cost of the dental care provided by my dentists is not covered by insurance, I am obligated to pay him/her such uninsured cost (the "Uninsured Costs") in accordance with his/her payment terms and policies. Finally, I certify that I had read or had read to me the contents of this form and understand the risks and limitations involved with the dental treatment that I am to receive.

SIGNATURE – PATIENT/GUARDIAN	DATE