REIGN DENTAL

Confidential Information Questionnaire

Please type or print below

Patient's Name Last First Middle Initial Date of Birth Gender M ☐ F ☐ Social Security # Marital Status M ☐ S ☐ D ☐ W ☐

Patient's Address Street Apt # City State Zip Home Phone

Patient's Employer Occupation Cell Phone

Work Address Street City State Zip Work Phone **E-Mail Address**

Spouse or Guardian Name Spouse/Guardian Employer Occupation Spouse/Guardian SSN#

Work Address City State Zip Work Phone Cell #

Emergency person we can contact (other than your family home) Work Phone Home Phone
Name Relationship

Names of other family members that are patients here **Who can we thank for referring you to our office?**

INSURANCE AND FINANCIAL INFORMATION

Insurance Company Name Insurance Address City State Zip Phone

Subscriber's Name Subscriber's Date of Birth Subscriber's SSN #

Group/Program Number Subscriber's Employer Employer's Address

Secondary Coverage: Insurance Company Name Insurance Address City State Zip Phone

Subscriber's Name Subscriber's Date of Birth Subscriber's Social Security#

Group/Program Number Subscriber's Employer Employer's Address

1. **What brings you to our office today?**
2. **Do you have any particular concerns?**
3. **What can we do to serve you better?**
4. Tell us your dental history: Ortho Y ☐ N ☐ Bad experiences Y ☐ N ☐ Wisdom teeth removed Y ☐ N ☐