Welcome to Dr. Roslyn Sim-Sabilano Dentistry Professional Corporation

CONFIDENTIAL INFORMATION QUESTIONAIRE

Medical Alert (Office Use Only) O Yes O No

O Mr. O Mrs. O Ms. O Miss O Dr.	O Adult O Child	O Male O Female	O Single O Married O Divorced O Widow/Widower
Patient name (LAST) (FIRST) (MIDDLE)	Date of Birth	SIN # (Optional)	
Address: Street Apt.# City Postal Code	Email:	Home Phone No.:	
Patient's / Guardian's employer:	Occupation:		
Work Address: Street City Postal Code	Mobile #:	Work #:	OK to call work O Y O N
Spouse`s Name: (LAST) (FIRST) (MIDDLE)	Spouse`s Employer	Occupation	
Work Address: Street City Postal Code	Mobile #:	Work #:	OK to call work O Y O N
Person we can contact in case of emergency (other than your family member) Name: Relationship: Home #: Work #: Mobile:			
Other family members who are patients at this clinic:	Who can we thank for referring you to our office?		

OFFICE POLICY:
Your appointment time will be reserved especially for you. If you are unable to keep the appointment, we will require* 48 hours notice. *Otherwise, it may be necessary for us to charge you for the time lost.

INSURANCE AND FINANCIAL INFORMATION

Primary Insurance Coverage O Y O N	Insurance Company	Address	Phone No.:
Subscriber's name	Patient's Relationship to Subscriber O Self O Spouse O Dependent	Subscriber's Date of Birth	SIN #:(Optional)
Employer (if different from above)	Employer address	Policy Plan# /Div/ Sec#	Subscriber's ID #
Secondary Insurance Coverage O Y O N	Insurance Company	Address	Phone No.:
Subscriber's name	Patient's Relationship to Subscriber O Self O Spouse O Dependent	Subscriber's Date of Birth	SIN #:(Optional)
Employer (if different from above)	Employer address	Policy Plan# /Div/ Sec#	Subscriber's ID #
Method of Payment: O Cash O Check O Credit Card: ____________ Number:______________________________Exp. Date:________			

ASSIGNMENT AND RELEASE

I hereby authorize my insurance benefits to be paid directly to the dentists. I am financially responsible for any balances due and authorize the dentists to release any information for this claim. I authorize that my records be used by the doctor if he/she so determines. In consideration of the services rendered to me by this dental office I am obligated to pay the said office in accordance with its credit terms and policy.

I consent to the making of videotapes, photographs, and x-rays before, during, and after treatment, and to the use of the same by the doctor in scientific papers or demonstrations.

I certify that I have read or had been read to me the contents pf this form and do realize the risk and limitation involved.

Signature:____ Date: ___________________________