8975 E. Golf Links Rd.
Tucson, AZ 85730
(520)886-6054
www.dentalcaretucson.com

# Confidential Information Questionnaire

## Patient Information

Patient Name: ________________________________, _______________________________, __________, _________________________
Last First MI Preferred Name

Address: _______________________________________________ City: ____________________ State: ______ Zip: _________________

Home Phone: (______)________________ Cell Phone: (______)_______________ Work Phone: (______) _______________

Patient Date of Birth: ________/________/________ Patient Social Security #: ________-______-________

How would you like to be reminded of your appointments? ◯ Phone ◯ Text Message ◯ Email

Email: _____________________________________ Whom may we thank for referring you? ____________________________________

Emergency Contact Phone: (______) _______________ Name: ________________________________Relationship:______________

## Billing Information (if different from above)

Name of responsible party: ______________________________________Relationship to patient:_______________________________

Address: _____________________________________________________________________________________________________

Home Phone: (______)________________ Cell Phone: (______)_______________ Work Phone: (______) ________________

Social Security #: _________-________-__________ Employer: ______________________________

**A firm financial arrangement is required before treatment. Patient's estimated portions are due the day services are rendered.**

**We accept the following payment options. Please indicate your choice below:**

◯ **Cash** ◯ **Check** ◯ **Visa** ◯ **M/C** ◯ **Disc** ◯ **AE** ◯ **CareCredit**

Dental Care on Golf Links will pursue any and all collection efforts including referring the account to a collection agency and/or attorney and reporting to the credit bureau. The patient account will be assessed all additional collection charges associated with the collection of debt including but not limited to collection fees, reasonable attorney's fees, court costs, and all other charges allowed by law.

## Dental Insurance

**Do you have dental insurance?** ◯ Yes ◯ No If yes, please list primary insurance below:

Name of Dental Insurance Company: _____________________________________ Employer: ___________________________________

Name of Employed Person: ____________________________________ Birth date of employed person: ______/______/_______

Insurance ID # or SSN: _________________________________ Group #: ______________________________

**Do you have secondary dental insurance?** ◯ Yes ◯ No If yes, please list secondary insurance below:

Name of Dental Insurance Company: _____________________________________ Employer: ___________________________________

Name of Employed Person: ____________________________________ Birth date of employed person: ______/______/_______

Insurance ID # or SSN: _________________________________ Group #: ______________________________

I hereby authorize my insurance benefits to be paid directly to Dental Care on Golf Links, PLC. I also authorize the doctor to release any information required to process insurance claims. I will pay the estimated portions for treatment the day of service and any balance after insurance has paid.

Date: __________________ Patient Signature: ___________________________________________

Date: __________________ Parent/Guardian Signature: _____________________________________________