



LARRY L. FOLDEN, D.D.S.

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**CONFIDENTIAL QUESTIONNAIRE**

PATIENT'S NAME: LAST FIRST MIDDLE

DATE OF BIRTH GENDER: M F SOCIAL SECURITY #

PATIENT'S ADDRESS: STREET APT# CITY STATE ZIP

EMAIL HOME PHONE CELL PHONE

MARITAL STATUS: MARRIED SINGLE 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 PHONE OK TO CALL WORK? YES NO

WORK ADDRESS: STREET CITY STATE ZIP

PERSON WE CAN CONTACT IN CASE OF EMERGENCY (OTHER THAN YOUR FAMILY HOME)

NAME RELATIONSHIP HOME # WORK # CELL #

OTHER FAMILY MEMBERS WHO ARE PATIENTS HERE

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?

**INSURANCE AND FINANCIAL INFORMATION**

INSURANCE? YES NO INSURANCE COMPANY NAME

ADDRESS CITY STATE ZIP PHONE

SUBSCRIBER'S NAME PATIENT'S RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE DEPENDENT

SUBSCRIBER'S DATE OF BIRTH: SUBSCRIBER'S SSN: GROUP/PROGRAM NUMBER

EMPLOYER (IF DIFFERENT FROM ABOVE) EMPLOYER ADDRESS

SECONDARY INSURANCE? YES NO INSURANCE COMPANY NAME

ADDRESS CITY STATE ZIP PHONE

SUBSCRIBER'S NAME PATIENT'S RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE DEPENDENT

SUBSCRIBER'S DATE OF BIRTH: SUBSCRIBER'S SSN: GROUP/PROGRAM NUMBER

EMPLOYER (IF DIFFERENT FROM ABOVE) EMPLOYER ADDRESS

**ASSIGNMENT & RELEASE:**

I hereby authorize my insurance benefits to be paid directly to Larry L. Folden, DDS. I am financially responsible for any balances due and authorize Larry L. Folden, DDS to release any information for this claim. I authorize that my records can be used by Larry L. Folden, DDS if he so determines.

In consideration of the services rendered to me by Larry L. Folden, DDS, I am obligated to pay 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 same by Larry L. Folden, DDS in scientific papers or demonstrations.

I certify that I have read or had read to me the contents of this form and do realize the risks and limitations involved.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

**NOTE: If remitting electronically via email or fax, patient will sign and date at first office visit.**