

DEXTER E. BARNES, D.D.S.
Confidential Information Questionnaire

Please type or print below

Patient's Name		Date of Birth		Gender	Social Security #		Marital Status	
Last	First	Middle Initial		M <input type="checkbox"/> F <input type="checkbox"/>			M <input type="checkbox"/> S <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/>	

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

Patient's Employer	Occupation	Cell Phone
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Work Address		City		State	Zip	Work Phone	E-mail Address
Street							

Spouse or Guardian Name		Spouse/Guardian		Spouse/Guardian	
Last	First	Employer	Occupation	Social Security #	

Work Address	City	State	Zip	Work Phone	Cell #
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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?
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INSURANCE AND FINANCIAL INFORMATION

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

Subscriber's Name	Subscriber's Date of Birth	Subscriber's Social Security #
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Group/Program Number	Subscriber's Employer	Employer's Address
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Secondary Coverage: Y <input type="checkbox"/> N <input type="checkbox"/>						
Insurance Company Name	Insurance Address	City	State	Zip	Phone	

Subscriber's Name	Subscriber's Date of Birth	Subscriber's Social Security #
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Group/Program Number	Subscriber's Employer	Employer's Address
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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 Perio Surgery Y N Wisdom teeth removed Y N