BACH SLEEP CENTER

I. Confidential Information Questionnaire

Patient Name: (First, MI, Last): _____

Date of Birth: _____ Sex: ☐ Male: ☐ Female: ☐

Cell Phone: _____ Email Address _____

Home Phone Numb: _____ Work Phone Number _____

Patient's Address

United States _____

State/Province _____

Marital Status

☐ Single ☐ Married/Common-law partner ☐ Widowed ☐ Divorced/Separated

☐ Under 18 ☐ Prefer not to answer

Who can we thank for referring you to our office?

_____

Employer (Patient's/Guardian's) _____

Occupation _____

II. Emergency Contact Information

Person we may contact in case of an emergency (other than your family home)

Name _____ Relationship _____

Cell Phone Number _____

Work Phone Number _____

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III. Request For Confidential Communication

As your dental sleep medicine provider, you may do the following with my permission:

- [ ] Check all
- [ ] Leave message on my voicemail / answering machine
- [ ] Contact me via email
- [ ] Contact me on the phone numbers provided
- [ ] I agree that the dental practice may communicate with me electronically at the email address and cell phone number i provided. I am aware that there is some level of risk that third parties might be able to read unencrypted emails or text messages.I am responsible for providing the dental practice any updates to my email address and cell phone number.

  I can withdraw my consent to electronic communications by contacting the dental office

IV. Confirmation

Do you prefer a reminder before you appointment

- [ ] No, it is unnecessary
- [ ] Yes, it is a helpful reminder

V. Dental Insurance And Financial Information

Dental Insurance Coverage [ ] Yes [ ] No

Dental insurance Company Name _____

Dental insurance Address _____

Dental insurance Phone Number _____

Subscriber's Name _____

Subscriber's ID _____

Patient's Relationship to Subscriber [ ] Self [ ] Spouse [ ] Dependent

Subscriber's Birthday _____

Subscriber's Address _____

Country _____

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Group/Program Number _____

Employer (if different from above) _____

Employer's Address

_____

_____

Secondary Coverage ☐ Yes ☐ No

Dental insurance Company Name _____

Dental insurance Address _____

Dental insurance Phone Number _____

Subscriber's Name _____

Subscriber's ID _____

Patient's Relationship to Subscriber ☐ Self ☐ Spouse ☐ Dependent

Subscriber's Birthday _____

Subscriber's Address _____

Country _____

Group/Program Number _____

Employer (if different from above) _____

Employer's Address

_____

_____

VI. Release Information

You may discuss my healthcare with

☐ Spouse/Common-law partner

☐ Children

☐ Parents Others: _____

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VII. Assignment & Release

As your dental sleep medicine provider, you may do the following with my permission:

I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic. I hereby authorize any available insurance benefits to be paid directly to my dentist if he/she accepts such an arrangement.

☐ I confirm that I have read and understood the terms & conditions.

I hereby authorize the making of videotapes, photographs, and x-rays of my dental care treatment (collectively "My Images"), and my dentist's use of My Images in scientific papers, demonstrations and/or presentations without compensation to me.

☐ I confirm that I have read and understood the terms & conditions.

Patient Signature

Date