J.J. Perkiomaki, D.M.D., P.C.
Sylvan Professional Bldg., 5415 SW Westgate Dr., #202, Portland, Oregon 97221 (503) 292-8996

CONFIDENTIAL INFORMATION QUESTIONNAIRE

Please Print

PATIENT'S NAME LAST	FIRST	MIDDLE	DATE OF BIRTH	SEX	SSN

PATIENT'S ADDRESS STREET	APT. #	CITY	STATE	ZIP	HOME PHONE

PATIENT'S E-MAIL ADDRESS	CELL PHONE

MARITAL STATUS M☐ S☐ D☐ W☐	PATIENT'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET	CITY	STATE	ZIP	WORK PHONE

SPOUSE'S NAME LAST	FIRST	MIDDLE	SPOUSE'S EMPLOYER	OCCUPATION

WORK ADDRESS STREET	CITY	STATE	ZIP	WORK PHONE

EMERGENCY PERSON WE CAN CONTACT (OTHER THAN YOUR FAMILY HOME)		
NAME	WORK PHONE	HOME PHONE

NAMES OF OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE	WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?

INSURANCE AND FINANCIAL INFORMATION

INSURANCE COVERAGE? YES☐ NO☐	INSURANCE COMPANY NAME	INSURANCE ADDRESS

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF☐ SPOUSE☐ DEPENDENT☐	SUBSCRIBER'S DATE OF BIRTH	SSN

GROUP / PROGRAM NUMBER	EMPLOYER — IF DIFFERENT FROM ABOVE	EMPLOYER'S ADDRESS

SECONDARY COVERAGE? YES☐ NO☐	INSURANCE COMPANY NAME	INSURANCE ADDRESS

SUBSCRIBER'S NAME	PATIENT'S RELATIONSHIP TO SUBSCRIBER SELF☐ SPOUSE☐ DEPENDENT☐	SUBSCRIBER'S DATE OF BIRTH	SSN

GROUP / PROGRAM NUMBER	EMPLOYER — IF DIFFERENT FROM ABOVE	EMPLOYER'S ADDRESS

ASSIGNMENT & RELEASE

I hereby authorize my insurance benefits to be paid directly to the dentist. I am financially responsible for any balance due and authorize the dentist to release any information required for this claim. I authorize that my records can be used by the doctor if he so determines.

In consideration of the service rendered to me by this dental office, I am obligated to pay said office in accordance with its credit terms and policy.

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

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

Signature _____ Date _____