Thomas E. Jacka, D.D.S.
700 S. 320th, Suite E
Federal Way, WA 98003
253-946-3575

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

MARITAL STATUS M☐ S☐ D☐ W☐	PATIENT'S EMPLOYER (PARENT OR GUARDIAN, IF A MINOR)	OCCUPATION

WORK ADDRESS STREET	CITY	STATE	ZIP	WORK PHONE

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

NAME WORK PHONE HOME PHONE

WHO CAN WE THANK FOR REFERRING YOU TO OUR OFFICE?	LIST OF FAMILY MEMBERS / DATE OF BIRTH

FAMILY MEMBERS (CONT.)

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

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. Payment for dental services provided in this office for myself or my dependents are due and payable at the time services are rendered. As a patient with dental insurance, I hereby authorize my insurance benefits to be paid directly to the dentist. I authorize the dentist to release any information required for this claim.

Note: For additional credit terms and policies consult with the receptionists.

Signature _____ ***Date*** _____
(PARENT OR GUARDIAN, IF A MINOR)

PLEASE TURN PAGE OVER

CONSENT FOR TREATMENT

1. I hereby authorize doctor or designated staff to take x-rays, study models, photographs, and other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of (name of patient) _____'s dental needs.

2. Upon such diagnosis, I authorize doctor to perform all recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetic, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

4. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that payment is due at the time of service unless other arrangements have been made. In the event payments are not received by agreed upon dates, I understand that a 1 1/2% late charge (18% APR) may be added to my account. If required, I also understand a check of my credit history may be made.

Patient's Signature _____ Date _____ Witness _____

Parent / Responsible Party's Signature _____

Relationship to Patient _____