

Dr. Soraya Bouzida, D.D.S.
Torrey Hills Family Dentistry

PATIENT QUESTIONNAIRE

Please complete both sides. This information is important for your dental care and will be kept confidential.

GENERAL INFORMATION

Date: ___/___/___

Patient Last Name _____ First Name: _____ Middle: _____
 Preferred Name: _____ Date of Birth: ___/___/___ Age: _____ Marital Status: _____ Female Male

Home Address Street: _____ City _____ Zip Code: _____
 Home Phone: (____) _____ Work phone: (____) _____ Cell: (____) _____ E-mail: _____

Occupation: _____ Employer: _____ Driver's License: _____ Social Security #: _____

Spouse's Name: _____
 Spouse's Occupation: _____ Spouse's Employer: _____
 Employer's Address: _____ Spouse's Work Phone: _____

Patient's Medical Doctor's Name: _____
 Address: _____ Phone: (____) _____

Name of Former Dentist: _____ Location: _____
 When was last dental visit? _____ For what purpose? _____
 Purpose of today's visit: _____ Date of last dental X-rays: ___/___/___

Emergency Contact Name: _____ Relationship: _____
 Address: _____ Phone #: (____) _____

FINANCIAL INFORMATION

Person Responsible for Payment: _____ Relationship to Patient: _____
 Address: _____ City _____ Zip Code: _____ Phone: (____) _____

Primary Insurance: _____
 Subscriber: _____ Social Security #: _____ Date of Birth: ___/___/___
 Insurance Company: _____ Phone: (____) _____ Group #: _____ Employer: _____
 Secondary Insurance:
 Subscriber: _____ Social Security #: _____ Date of Birth: ___/___/___
 Insurance Company: _____ Phone: (____) _____ Group #: _____ Employer: _____

FINANCIAL RESPONSIBILITY I understand that I am financially responsible, whether my insurance company pays or not, for all charges incurred by me (or my dependents). I further agree that in the event of non-payment, I will bear the costs of collection and/or court costs and reasonable legal fees should such court action be required. I agree that a photocopy of this authorization shall be valid as the original.
 SIGN NAME: _____ DATE: _____

Authorization for Signature on file and Consent for release of information to Insurance Company
 I hereby authorize Dr. Soraya Bouzida, D.D.S. to bill my insurance company directly to receive payment from the insurance on my behalf, to furnish any information necessary to complete and/or settle my dental claim.
 Signed _____ Date _____

I have received/read a copy of the **Dental Materials Fact Sheet**.
 I have had the opportunity to read it and discuss the information with my dentist prior to placement of my dental restorative work.

Initial _____ Date _____

I have read a copy of the **Notice of Privacy Practices** provided by Dr. Soraya Bouzida, D.D.S.

Initial _____ Date _____

HOW DID YOU HEAR ABOUT OUR OFFICE? Sign on building Our Website Walk-in
 Dental Plan Friend/Relative Referred by Other

