Welcome To Our Practice

Thank you for choosing our office for your dental needs. Please take a few minutes to complete this confidential questionnaire so we may better serve you.

Date: ____/____/____

Patient Name: _____ Sex: M F Birthdate: ____/____/____

Patient Address: _____ City: _____ State: ____ Zip: _____

Social Security #: ____-___-_____ Home Phone (____) ____-_____ Business Phone (____) ____-_____ Ext: ____

Patient's Employer: _____

Marital Status: Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐

Billing Name (person responsible for account): _____ Is this Self ☐ Spouse ☐ Parent ☐

Billing Address (if different from home address): _____

Phone number at billing address (if different from home number): _____

Emergency contact information: Name: _____ Relationship: _____ Phone:(____) ____-_____

How did you learn of our office? _____

If applicable, what is the relationship of the referring person to you? _____

PRIMARY DENTAL CARRIER

Ins. Co. Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Group/Policy Number: _____

Employer: _____

Employee: _____

Employee Social Security Number: _____-_____-_____

Employee Date of Birth: _____

Relationship to Patient: Self ☐ Spouse ☐ Parent ☐

SECONDARY DENTAL CARRIER

Ins. Co. Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Group/Policy Number: _____

Employer: _____

Employee: _____

Employee Social Security Number: _____-_____-_____

Employee Date of Birth: _____

Relationship to Patient: Self ☐ Spouse ☐ Parent ☐