

GET ACQUAINTED QUESTIONNAIRE

Thank you for selecting our dental healthcare team. We will strive to provide you with the best possible dental care. To help us meet all of your dental health care needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Date _____

Patient's Name _____ Date of Birth _____

Address _____ City _____ Zip _____

E-Mail _____ Driver's License # _____

Home Phone _____ Cell Phone _____ Work Phone _____

Occupation _____ Employer _____

Employer's Address _____ City _____ Zip _____

Spouse's Name _____ Employer _____ Phone _____

Person Financially Responsible _____ Relation to you _____

Name

Date of Birth

Social Security Number

Mr. _____

Mrs. _____

Child _____

Child _____

Child _____

Child _____

Former Dentist _____

Last Visit _____

Physician _____ Phone _____

Whom May We Thank For Referring You _____

Reason For Appointment _____

For Patients With Dental Insurance

Dental Ins. Carrier _____ Group Policy # _____

Additional Dental Insurance _____

I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to my child or myself to third party payors and/or health practitioners. I authorize and request my insurance company to pay insurance benefits directly to the dentist. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on behalf of myself or my dependents.

Signature _____ Date _____