

GET ACQUAINTED QUESTIONNAIRE

Date: _____

Circle one: Miss Ms. Mr. Mrs. Dr. Rev.

Have you or any family member previously been in this office? _____

PATIENT INFORMATION

Name: _____ Nickname: _____ Date of Birth: _____
Last First Middle

Address: _____ City: _____ State: _____ Zip: _____

Telephone Number: () _____ Circle One: Single Married Divorced Separated Widow Widower

Email: _____ Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Business Phone #: _____ Cell Phone #: _____

Student: Full Time Part Time Name of School: _____

SPOUSE INFORMATION: (Parent Where Applicable)

Name: _____ Birth Date: _____ Relationship: _____
Last First Middle

Address: _____ City: _____ State: _____ Zip: _____

Telephone #: () _____ Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____ Years Emp: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Business Phone #: () _____ Cell Phone#: _____

Do You Have Dental Insurance Coverage? _____ Does Your Spouse? _____

If yes, please complete the following information completely so that we can assist you in obtaining your benefits.

Dental Insurance Company #1 _____ The Subscriber Is: Self _____ Spouse _____ Parent _____
Group #: _____ ID #: _____

Dental Insurance Company #2 _____ The Subscriber Is: Self _____ Spouse _____ Parent _____
Group #: _____ ID #: _____

Second insured person if not patient

Name: _____ Birth Date: _____ Relationship: _____
Last First Middle

Address: _____ City: _____ State: _____ Zip: _____

Telephone #: () _____ Social Security #: _____ Driver's License #: _____

Employer: _____ Occupation: _____ Years Emp: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Business Phone #: () _____ Cell Phone #: _____

PLEASE READ: THE PATIENT IS RESPONSIBLE FOR ALL FEES REGARDLESS OF INSURANCE COVERAGE. IT IS CUSTOMARY TO PAY FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE.
* PLEASE TURN AND COMPLETE HEALTH HISTORY RECORD ON REVERSED SIDE *