PATIENT QUESTIONNAIRE

Date _____

Patient's Name _____ Single Married Separated Divorced Widowed
Name of Spouse_____ If child, Parent's Name _____
Home Address _____ City _____ State _____ Zip _____
Business Address _____ City _____ State _____ Zip _____
Telephone: Home _____ Business _____ Cellular _____
Patient (parent) Employed by _____ Present Position _____ How long? ____
Spouse Employed by _____ Present Position _____ How long? ____
Referred by _____ Who will pay this account? _____
Patient's (parent's) Social Security No. _____ Spouse's SSN _____
Purpose of Call _____
Date of Birth _____ Age _____ Email Address _____

Dental Insurance:

Dental Ins. Co. Name	Group/Policy #	SS# of Policyholder	Date of Birth of Policyholder
Primary:			
Secondary:			
Additional:			

DENTAL HISTORY

Do you have any present dental complaints? _____
When was your last full mouth x-ray taken? _____ When was your last cleaning?_____
Have you ever been instructed in the prevention of decay? _____ In caring for your gums? _____

To the best of my knowledge, all of the preceding answers are true and correct. If I have a change in my health or medications, I will inform the dentist at the next appointment.

If appointments are cancelled without 24 hours prior notice, a failed appointment fee may be charged.

A 1.5 % per month service charge will be applied to outstanding balances over 30 days.

_____

Signature of Patient, parent, or guardian Date