CONFIDENTIAL HEALTH QUESTIONNAIRE AND ACQUAINTANCE INFORMATION

Date _____ Patient's Social Security # _____

Patient's Name _____ Patient's B'day _____ Age _____

Address _____ City _____ State _____ Zip _____

Home Phone _____ Business Phone _____

Married _____ Single _____ Separated _____ Divorced _____ Widowed _____

Place of Employment _____

Address of Employment _____ Phone # _____

Name of Insurance Company _____

Address of Insurance Company _____

Spouse Information: Name _____ B'day _____

Social Security # _____

Place of Employment _____

Address of Employment _____ Phone # _____

Name of Insurance Company _____

Address of Insurance Company _____

Person Responsible for Account _____

Relationship to Patient _____

Past Dental History:

1. Who is your general dentist? _____
2. How often do you usually see the dentist? _____
3. How often do you usually get your teeth cleaned? _____
4. When were your teeth cleaned last? _____
5. Do you brush your teeth more than once a day? _____
6. Do you floss your teeth? _____
7. How long have you known that you have a gum problem? _____
8. Have you had periodontal treatment before? _____
9. Do you want to keep your natural teeth? _____
10. Have you ever received an injury to a tooth? _____
11. Have you ever had orthodontic treatment (braces)? _____
12. Do you grind or clench your teeth? _____
13. Do you:

Ever have sore teeth	YES	NO
Have a relative with Diabetes	YES	NO
Have unpleasant tastes in your mouth	YES	NO
Have bleeding gums	YES	NO
Have tooth sensitivity to heat, cold or sweets	YES	NO
Use Dental Floss	YES	NO

_____ _____

Signature of Patient or Responsible Party Date

Payment is expected at time of office visit unless prior arrangements have been made.

Insurance will be filed from this office on surgical claims and pre-estimate will be filed before work begins. We are happy to cooperate with you in this matter, but payment of your bill is your responsibility.

Thank you for your cooperation.

Gillespie & Harrell Printers (229) 436-1584