GET ACQUAINTED QUESTIONNAIRE

Patient's Name: _____ **Date:** _____
(First) (Initial) (Last)

Name you prefer to be called: _____ **Male** _____ **Female** _____ **Birth date:** _____

Home Address: _____
(Street) (City) (Zip)

Social Security No. _____ **Home Phone:** _____

Occupation: _____ **Business phone:** _____

Email address: _____ **Cell No:** _____

Employer : _____

If child, names of both parents: _____

Spouse's name: _____ **Responsible Party:** _____

Whom may we thank for referring you? _____

DENTAL INSURANCE INFORMATION

Name of Insurance Co. _____

Address _____
(Street) (City) (State) (Zip)

Policy or Group No. _____ **Subscriber No.** _____

Employee Name: _____ **Birth date:** _____

Social Security No. _____ **Relationship to Patient** _____

Employer (Company Name) _____

Address _____
(Street) (City) (State) (Zip)

IF COVERED BY TWO DENTAL INSURANCE PLANS, PLEASE ANSWER BELOW

Name of Insurance Co. _____

Address _____
(Street) (City) (State) (Zip)

Policy or Group No. _____ **Subscriber No.** _____

Employee Name: _____ **Birth date** _____

Social Security No. _____ **Relationship to Patient** _____

Employer (Company Name) _____

Address _____
(Street) (City) (State) (Zip)

DENTAL HISTORY

Do you have any present dental concerns? Yes _____ No _____

If yes, please explain _____

When was your last dental cleaning? _____Were X-rays taken? Yes _____ No _____

Previous Dentist _____

Do you have or have you had any of the following?

Yes	No		Yes	No	
____	____	**Bleeding gums**	_____	_____	**Root canal therapy**
_____	_____	**Offensive breath**	_____	_____	**Orthodontic treatment**
_____	_____	**Clench or grind teeth**	_____	_____	**Bridges, partials or dentures**
_____	_____	**Clicking in jaw joint**	_____	_____	**Tooth sensitivity**
_____	_____	**Gum surgery**	_____	_____	**Do you use tobacco products?**
_____	_____	**Dry Mouth**			