NEW PATIENT QUESTIONNAIRE

Today's Date: _____

Full Name: _____ **Soc. Sec. #:** _____

Birth Date:_____ **Male** **Female (please circle one)**

Home phone: ( ) _____ **Cell phone: ( )** _____

Address: (Street) _____ **PO Box** _____ **(if applicable)**

City, State, Zip: _____

May we contact you via e-mail? _____ **E-mail address:** _____

Place of Employment: _____ **Work phone: ( )** _____

Name of Employer: _____**Can we call you at work?** _____ **YES** ____ **NO**

Employer's Address: _____

City, State, Zip: _____

Marital Status: Single_____ **Married**_____ **Divorced**____ **Widowed** _____

***If a Minor*, Father's Name and Work Ph.** _____

Mother's Name and Work Ph. _____

***If Married*, Spouse's Name and Work Ph.** _____

Spouse's Place of Employment Address: _____

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All information needs to be Complete to process Insurance Claims

Policy Holder's Name: _____

Policy Holder's Birth Date: _____ **Policy Holder's SSN:** _____

Relationship of Patient to Policy Holder: _____ **Group #** _____

Name of Dental Insurance/Address: _____

Policy Holder's Place of Employment (Street, City, State): _____

If there is a secondary insurance fill out the following

Policy Holder's Name: _____

Policy Holder's Birth Date: _____ **Policy Holder's SSN:** _____

Relationship of Patient to Policy Holder: _____ **Group #** _____

Name of Dental Insurance/Address: _____

Policy Holder's Place of Employment (Street, City, State): _____

Please list how or from whom you heard about our office: _____

May we send a Thank you to him/her? Yes No

Having a dental home for dental records is important. With your agreement we will ask to have your dental records transferred here.

Is that ok? __Yes __No ***If so,* previous Dentist's name/address:**

_____

_____

Your signature: _____ **Date:** _____

Person completing this form:(Please PRINT) _____

If other than patient, indicate relationship: _____