

Personal Questionnaire

Name: _____

Date: _____

About you, the patient

I prefer to be called _____

Male _____ Female _____

Birthdate ____/____/____ Age _____

Soc Sec # _____

Single Married Divorced Widowed Separated Child

Home address _____

Visits confirmed by email? _____

Home tel _____ Cell _____

Work tel _____ Ext _____

Other family members seen by us

Person responsible for account

Name _____

Employer's name _____

Employer's address _____

Employers' tel _____

Birthdate ____/____/____ Age _____

Occupation _____

How long employed? _____

Full time _____ Part time _____ Retired _____

When and where are the best times to reach you?

Dental Insurance

Primary Dental Insurance

Insured's name _____ Relation _____

Insured's birthdate ____/____/____

Insured's Soc Sec # _____

Insured's employer _____

Insurance Co name _____

Insurance Co address _____

Insurance Co tel _____

Group # (Plan, Local or Policy#) _____

Secondary Dental Insurance

Insurance Co name _____

Insurance Co address _____

Insurance Co tel _____

Group # (Plan, Local or Policy#) _____

Insured's name _____ Relation _____

Insured's birthdate ____/____/____

Insured's Soc Sec # _____

Insured's employer _____

In the event of an emergency, is there someone who lives near you that we should contact?

Name _____ Relation _____

Tel _____