

## 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?**

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