

GET ACQUAINTED QUESTIONNAIRE

Welcome to our office, help us serve you better

PLEASE PRINT

PATIENT INFORMATION

E-Mail _____

Patient's Name	Address	ZIP
If child, father's name	S.S. Number	
Telephone: Home	Work	Number we can call in the daytime to confirm your appointment:
Age:	Birthdate	Single [] Married [] Separated [] Divorced [] Widowed []
Spouse's Name	Age:	Birthdate: Your Home: Own [] Rent [] How long?
Your Occupation	Name & Address of Employer	How Long
Spouse's Occupation	Name & Address of Employer	How Long
Your hobbies	Who referred you to our office	
Purpose of visit	Previous Dentist	
Person financially responsible	Address	Phone Number
Other members of your family who are patients here		
Who can we contact in case of emergency other than spouse?	Name	Address Phone Number

CREDIT INFORMATION

Do you wish to apply for credit with us?

Name of your Bank BRANCH:

Savings [] Checking []

Credit Card Number:

M/C:

VISA:

Expiration Date:

Credit Union:

Other credit:

INSURANCE INFORMATION

Fill this out if you are covered by dental insurance

Insured Person	Insurance Company	
Soc. Security Number of insured	Group No. of policy	Union or Local No.
Second Insured Person	Insurance Company	
Soc. Security Number	Group No.	Union or Local No.

Please provide us with your insurance form. We will complete it for your convenience

CONSENT

I consent to treatment as necessary or desirable to care of the patient named above, including but not restricted to whatever drugs, or studies that may be used by the attending doctor, or his nurse or qualified designate.

I also acknowledge full responsibility for the payment of such services and agree that I will take the responsibility for any and all costs incurred by my failure to remit for services rendered. I will allow this office to contact me during business hours for the purpose of confirming an appointment or gathering information.

A SERVICE CHARGE OF 1½% per month will be charged on all accounts over 30 days old. 1½% per month equals per annum interest of 18%.

SIGNED _____
Patient or Parent

Date _____