Adult Questionnaire

Please fill in your answers as thoroughly as possible. In our office we are interested in developing a complete dental health program for you. In order to do this we must know as much about the individual as we do about his teeth. No two people are the same; no two mouths are alike. All information, of course, will be held in strict confidence.

By working together, we can strive to keep your natural teeth and thus improve your enjoyment of food, your appearance, your comfort and your health for the rest of your life.

Date _____

Patient's Name _____ Date of Birth _____

Name (Husband or Wife) _____

Home Address _____

City _____ State _____ ZIP _____

Home Phone _____ What is your occupation? _____

_____

Are you associated with a Dental Insurance Plan? _____ If so,

Carrier Name & Address _____

_____ Phone # _____

For what company do you work? _____

Address _____

Business Phone _____ Ext. _____

If married, occupation of your husband (or wife) _____

For what company does he (she) work? _____

Address _____

Phone _____ Ext. _____

Insurance Carrier Name & Address _____

_____

Phone # _____ Number of Children in Family? _____

Ages _____ Patient Medical Alerts _____

Patient's Social Security No. _____

(Husband or Wife) Social Security No. _____

Name & address of person responsible for payment _____

_____

Whom may we thank for referring you to our office? _____

_____ Thank You