New Patient Questionnaire

Today's Date _____ /_____ /_____

How did you hear about us? _____

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

Do any other family members come here? _____

Patient Information

First Name _____ MI _____ Last Name _____

Date of Birth _____ /_____ /_____ Gender _____ Social Security #_____

Contact Information (☐ Best Number we can reach you at)

☐Home # _____ ☐Cell # _____ ☐Work #_____

Mailing Address: _____
E-mail Address: _____

Dental History

When was your last visit to the dentist? _____ What for? _____

Did you have any X-rays taken in the last year? Yes / No May we request copies? Yes / No

If "Yes", Please share dentist name _____ & Phone # _____

Insurance Information (☐ All that apply)

☐ Dental Insurance ☐ Care Credit ☐ Self Pay (no insurance)

Insurance Provider _____ ID # _____

Subscriber: Name _____ Subscriber DOB _____ / _____ / _____

Subscriber Social Security # _____

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