CONSULT AND NEW PATIENT QUESTIONNAIRE

Date: _____

Full Name:_____
FIRST MIDDLE LAST

Date of Birth:_____ Age:_____ Gender: F M
DAY MONTH YEAR

Home Address:_____
STREET

_____
CITY POSTAL CODE

ALL PHONE NUMBERS WHERE WE CAN CONTACT YOU: (CIRCLE MOST PREFERRED NUMBER)

Home:_____ Work:_____ Cell:_____

Other:_____ Email Address:_____

How did you find us? Advertising or Referral

If from a referral, who may we thank? _____

Person Responsible For Account _____
self or name of other responsible person

Do you have dental insurance? Y N

Type: _____ Employer: _____

Do you have secondary dental insurance? Y N

Secondary Insurance Holder's Full Name:

_____ DOB: _____

Type: _____ Employer: _____

DENTAL INFORMATION

Exceeding Expectations!

How would you rate your oral condition on a scale of 1 to 10? _____