

# Welcome to Our Practice!

## Patient Questionnaire

### **Patient Information**

Name: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_  
Address: \_\_\_\_\_ City \_\_\_\_\_ zip \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Day time #: \_\_\_\_\_  
Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ Email: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work #: \_\_\_\_\_  
Occupation: \_\_\_\_\_ SSN: \_\_\_\_\_  
If under 18, Mother's name: \_\_\_\_\_ Father's name: \_\_\_\_\_

### **Responsible Party (if other than patient)**

Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Work #: \_\_\_\_\_  
Birth date: \_\_\_\_\_ SSN: \_\_\_\_\_ Day time #: \_\_\_\_\_

### **Primary Dental Insurance**

Policy holder's name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Policy holder's DOB \_\_\_\_\_ SS# \_\_\_\_\_  
Policy holder's employer: \_\_\_\_\_  
Insurance company: \_\_\_\_\_ Phone \_\_\_\_\_  
Policy/Group #: \_\_\_\_\_

### **Secondary Dental Insurance (If Applicable)**

Policy holder's name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Policy holder's DOB \_\_\_\_\_ SS# \_\_\_\_\_  
Policy holder's employer: \_\_\_\_\_  
Insurance company: \_\_\_\_\_ Phone \_\_\_\_\_  
Policy/Group #: \_\_\_\_\_

### **Medical Insurance**

Policy holder's name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Policy holder's DOB \_\_\_\_\_ SS# \_\_\_\_\_  
Policy holder's employer: \_\_\_\_\_  
Insurance company: \_\_\_\_\_ Phone \_\_\_\_\_  
Policy/Group #: \_\_\_\_\_

Emergency contact \_\_\_\_\_ Phone # \_\_\_\_\_

Family member names who are patients here \_\_\_\_\_

### **AUTHORIZATION**

The undersigned affirm that the information given in this questionnaire is true and accurate to the best of my knowledge. I authorize staff to perform such dental services as may be necessary and authorize the release of written records to any referring or treating dentist, physician, medical facility or insurance company or for legal documentation.

I accept full responsibility for all changes for treatment to the patient regardless of insurance coverage.

Signature \_\_\_\_\_ Date \_\_\_\_\_  
Relationship to patient \_\_\_\_\_