DETAIL DENTAL

NEW PATIENT QUESTIONNAIRE

PATIENT INFORMATION

NAME: _____ DOB: _____ *mm/dd/yy*

SSN# _____ Gender: ☐ Male ☐ Female

Street Address: _____ *Street* *City, State Zip*

Email: _____ Cell Phone: _____

How did you hear about us: _____

Main concern or reason for coming in today:

_____

_____

_____

INSURANCE

Carrier Name: _____

Employer name: _____

Subscriber ID: _____

Group ID _____

PERSONAL DENTAL GOALS

Do you have any missing teeth? ☐ Yes ☐ No Considered replacing? ☐ Yes ☐ No

Is there anything about your smile that you would like to change? ☐ Yes ☐ No

_____

Is it important for you to keep your teeth the rest of your life? ☐ Yes ☐ No

How do you sleep at night? Do you wake up well-rested? ☐ Yes ☐ No Do You Snore? ☐ Yes ☐ No

Besides lower costs, what is important to you in regard to a new dental office?

_____

Are there certain aspects you would like or maybe ones that you don't like?

_____

_____

_____

Is there anything else about your dental history you would like the doctor to know?

_____

_____

_____