

Acquaintance Form

Date _____ Single _____ Married _____ Widowed _____ Divorced _____
Patient Name _____ SSN _____

Home Address _____ Zip _____
Home Phone _____ Cell Phone _____ Birth Date _____

Employer _____ Occupation _____
Business Address _____ Business Phone _____

Name of Insured _____ Insurance Carrier _____
Insurance Address _____
Group Number _____ Social Security Number _____
Insured Date of Birth _____ Insured Employer _____

Secondary Insurance Coverage
Name of Insured _____ Insurance Carrier _____
Insurance Address _____
Group Number _____ Social Security Number _____
Insured Date of Birth _____ Insured Employer _____

How would you like us to confirm your appointments? Email ___ Cell ___ Home ___ Work ___
Email address _____ Cell _____
Other members of your family seen in this office _____
Whom may we thank for this referral? _____

These are the things that are important to me about my Dental Health: (check one)

1. I (I am) . . . think the appearance of my mouth is excellent.
satisfied with the appearance of my mouth
dissatisfied with the appearance of my mouth.
2. I . . . will do anything to keep my teeth.
want to keep my teeth, but have a certain budget of time and money
don't care whether I keep my teeth or not
3. **What are your goals for your dental health?** (check all that apply)
preventive care
better appearance
save money
avoid pain
4. I . . . have always done the best that was recommended for my dental health
have not done what dentists have recommended for my mouth
rarely go, and don't care much about having my dental care completed

5. I have . . . put dentistry for myself and my family high on my priority list.
put dentistry for myself and my family low on my priority list.
It's on my list but it's hard to find.

6. What are some questions about dentistry and oral health that you have never had adequately answered for you? _____

7. If you had a magic wand, what would you change about your teeth or smile?
