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PERIODONTAL
ASSOCIATES

A Professional Dental Team Emphasizing
Preventative Periodontics, Implants and Wellness

ACQUAINTANCE FORM

In order to aid in evaluating your dental health thoroughly and completely, please complete the following examination questionnaire. This will be held in complete confidence.

Since the initiation and progression of oral disease is affected by a combination of many complex elements, it is necessary to investigate and resolve every possible contributing factor. The success of therapy is therefore most dependent upon complete information on this history. Though some of the following questions may seem unrelated to your oral condition, they are all associated with proper management of your oral health.

Date _____

Name _____ Preferred Name _____

Home Address _____ City _____ State _____ Zip _____

Home Phone _____ Cell Phone _____ E-Mail Address _____

Age _____ Date of Birth _____ Social Security Number _____

Occupation _____ Work Phone _____

Employer Name _____

Work Address _____ City _____ State _____ Zip _____

Spouse's Name _____

Spouse's Employer _____ Work Phone _____

Work Address _____ City _____ State _____ Zip _____

Age _____ Date of Birth _____ Social Security Number _____

Responsible Party/Insurance Information

Person Responsible for this Account _____ Date of Birth _____

Relationship to Patient _____ Home Phone _____

Home Address _____ City _____ State _____ Zip _____

Social Security Number _____ Work Phone _____

Responsible Party's Employer _____

Work Address _____ City _____ State _____ Zip _____

Insurance Company _____ Group # _____

Insurance Phone# _____

Whom may we thank for referring you? _____

Purpose of appointment _____

Are any other family members patients of this practice? _____