



## QUESTIONNAIRE

1. When was your last visit to a dentist? \_\_\_\_\_
2. What is your visit for? (circle one)  
Checkup, toothache, consult,  
cleaning, other: \_\_\_\_\_
3. List any medications you are taking,  
prescription and non prescription  
(aspirin, vitamins, birth control,  
Tylenol, Advil) \_\_\_\_\_
4. List any allergies to medications—  
Penicillin, Codeine, local anesthesia,  
other: \_\_\_\_\_
5. Physician's name \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone # \_\_\_\_\_
6. Insurance Information:  
Insured's Name \_\_\_\_\_  
Social Security # \_\_\_\_\_  
Employer \_\_\_\_\_  
Insurance Company \_\_\_\_\_  
Union/Group Name/Local # \_\_\_\_\_  
Group # or Policy # \_\_\_\_\_  
Date Employed \_\_\_\_\_

Please bring this questionnaire with you when you come for your appointment.

Sincerely,

Colors shown on proof are not actual colors to be printed. For internal use



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