# ACQUAINTANCE FORM

Patient Name_______________________________________________Date________

Birth Date_______________________Social Security #________________________

Spouse's Name_________________________________________________________

Birth Date_____________________ Social Security #__________________________

Residence______________________________________________Zip____________

Home Phone (        )______________Email___________________________________

Cell Phone(        )___________Work Phone(        )___________Fax(        )___________

Employer______________________________Position_________________________

Spouse's Employer______________________ Business Phone (___)______________

Present Position_________________________ Person responsible for account?_______

Whom may we thank for this referral?_______________________________________

Dental Insurance: Yes_______No_______Insurance Co__________________________

Employee_______________Group #____________________Phone(        )____________

Address________________________________________________________________

What prompted you to seek dental care at this time?_____________________________

Are you pleased with the present appearance of your teeth?________________________

_______________________________________________________________________

Have you ever had braces before?__________________________________________

If you could change anything about your smile, what would it be?___________________

_______________________________________________________________________

Name of previous dentist?_________________________________________________

May we request your dental records to facilitate proper treatment in our office?________