LIBERTY CENTER
DENTAL CARE

Patient Questionnaire

This questionnaire was designed to provide important facts regarding the history of your pain or condition. The information you provide will assist in reaching a diagnosis and determining the best treatment. Please take your time and answer each question as completely and honestly as possible.

TODAY'S DATE: _____

PATIENT INFORMATION

Name _____ _____ _____

First Middle Initial Last

Date of Birth: _____ SSN: _____

E-mail address: _____ Phone number: _____

PRIMARY DENTAL INSURANCE

Patient's relationship to insured ☐ Self ☐ Spouse ☐ Not applicable

Carrier: _____ Subscriber ID #: _____

Group Plan: _____ Group #: _____

Is your dental insurance through your employer? ☐ Y ☐ N

Employer name: _____ Phone number: _____

Employer Address: _____

_____

SECONDARY DENTAL INSURANCE

Patient's relationship to insured ☐ Self ☐ Spouse ☐ Not applicable

Carrier: _____ Subscriber ID #: _____

Group Plan: _____ Group #: _____

Is your secondary dental insurance through your employer? ☐ Y ☐ N

Employer name: _____ Phone number: _____

Employer Address: _____

_____

Family Physician: _____

*What are your expectations of our dental office?

_____

*What type of music do you enjoy?

_____