Taneyhill & Mandras, LLC

Date:_____

Last Name: _____ First Name:_____ MI.____

Birthdate:_____ Age:_____ Social Security Number:_____

Address:_____

City:_____ State:_____ Zip:_____

EMAIL:_____

Employed By:_____ Occupation:_____

Home Phone:_____ Work:_____ Cell:_____

Spouse's Name:_____ Employed By:_____

How did you hear about our office?_____

Person responsible for this account:_____

Name of Dental Insurance Company:_____

Policy Holder Name:_____ Date of Birth:_____

Policy Holder Employer:_____

Group #:_____ Policy or SS#:_____

Health Questionnaire:

Are you allergic to anything? _____ yes no_____
List_____

Are you under the care of a physician? _____ yes no_____

Have you ever had an excessive bleeding requiring special treatment? ____ yes no___

Are you happy with the appearance of your smile? _____yes no_____

When was your last dental visit? _____