NEW PATIENT QUESTIONNAIRE

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE:\_\_\_\_\_\_\_\_\_\_\_

**DENTIST’S NAME**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

At Benson Orthodontics, we want to see how our patients hear about us and what motivated you to call our office. Thank you in advance for your time! Check all that apply.

We know from our initial conversation that you heard about us from\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

We would appreciate your help by indicating any other ways you saw or heard about our office.

* My dentist
* My family member was treated/is being treated by Dr. Benson, friend, neighbor, co-worker or one of our patients recommended you (Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
* Heard about you through school, sports, church or community activity(Please circle)
* Damon website referred me
* Your staff referred me to the office (Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)
* Received your postcard
* Internet
* Saw your sign while driving by
* Invisalign referred me
* Other (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

**What is your main concern?**

Overjet (buck teeth) Spaced teeth Crooked/Crowded teeth

    

**What treatment option are you most interested in?**

 Metal Braces Clear Braces Invisalign



**What payment options would be best for you?**

\_\_\_\_Payment in full with special discount \_\_\_\_ Care Credit

\_\_\_\_In-house financing – no interest \_\_\_\_ Flexible Spending Account

**Do you have insurance or flex plan benefits you would like for us to confirm?**

\_\_\_ Yes

 \_\_\_ No

 If so, please provide the following: Subscriber’s Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 DOB \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 SSN \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Card ID # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Insurance \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Insurance Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Is there anyone else who is going to be involved in the decision to start treatment?**

\_\_\_ Yes Involved party \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ No

**Have you had another orthodontic consultation?**

\_\_\_ Yes Dentist/orthodontist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ No

**Are you allergic to latex or any medications?**

------Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_No

**Are there any health concerns we should be aware of?**

\_\_\_ Yes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_ No

**On a scale of 1 to 5, with 5 being ready to start, how ready to start are you?**

1 2 3 4 5

**Please sign for permission to:**

 \_\_\_ Permission to take x-rays, photos

 \_\_\_ Post name and photo in contests/social media

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**We appreciate your thoughts!!! Dr. Benson and TEAM**