## SEAN S. LEE, D.D.S., INC.

## 4016 University parkway, San Bernardino, Ca. 92407 **GET ACQUAINTED QUESTIONAIRRE**

Name: Mr. Mrs. Ms. Miss (Please circle one) Last Name, First Name Middle Name Social Security Number Driver's License Number Residence Address City Zip How long at this address? Phone E-Mail Address Best phone number to call Best time to call Your Occupation Employer Phone Employer's Address City Zip Phone Caxt.  Spouse Information or Parent information in case of minor Name Cast Name, First Name Middle Name Social Security Number Birth Date Employer's Address City Zip Phone Caxt.  Person Financially Responsible: Relation to You Children - Name - Age Former Dentist Phone 1.  Physician Phone 2.  Relationship Phone 2.  Birth Date The Middle Name Social Security Number Birth Date Employer's Address City Zip Phone Caxt.  Person Financially Responsible: Relation to You Children - Name - Age Former Dentist Phone 1.  Physician Phone 2.  Birth Date City Zip Phone Number # 1 Phone Number # 2  How did you hear about this office? (Please Circle) Phone Book, Sign, Ad, Other If patient referred then who referred you to us?  Insurance Carrier (Mr.) (Mrs.) Phone Group Number Union Local  Will you be requiring credit (financing) by our office for your dental care? (Please circle) Yes, No  I have read all information on both sides of this sheet and have completed the above questions.  I certify this information is true and correct to the best of my knowledge.  Signature (Parent if minor)  Date	<b>Patient Information</b>					
Social Security Number Residence Address City Zip How long at this address? Phone E-Mail Address Best phone number to call Best time to call Your Occupation Employer Phone Employer's Address City Zip Phone ext.  Spouse Information or Parent information in case of minor Name Occupation Last Name, First Name Middle Name Social Security Number Birth Date Employer's Address City Zip Phone cxt.  Person Financially Responsible: Relation to You Children - Name - Age Former Dentist Phone 1.  Physician Phone 2.  Whom may we contact in case of emergency? Relationship Phone Book, Sign, Ad, Other If patient referred then who referred you to us?  Insurance Carrier (Mr.) (Mrs.) Phone Group Number Union Local Will you be requiring credit (financing) by our office for your dental care? (Please circle) Yes, No  I have read all information on both sides of this sheet and have completed the above questions. I certify this information is true and correct to the best of my knowledge.	Name: Mr. Mrs. Ms. Miss ,			Birth Date		
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E-Mail Address Best phone number to call Best time to call Your Occupation Employer's Address City Zip  Phone ext.  Spouse Information or Parent information in case of minor  Name Occupation  Last Name, First Name Middle Name  Social Security Number  Employer's Address City Zip  Phone ext.  Person Financially Responsible: Relation to You  Children - Name - Age  Former Dentist Phone 1.  Physician Phone 2.  3.  Whom may we contact in case of emergency?  Relationship Phone Number # 1  Phone Number # 2  If patient referred then who referred you to us?  Insurance Carrier (Mr.) (Mrs.) Phone Group Number Union Local  Will you be requiring credit (financing) by our office for your dental care? (Please circle) Yes, No  I have read all information on both sides of this sheet and have completed the above questions. I certify this information is true and correct to the best of my knowledge.	Social Security Number		Dı	river's Lice	nse Number	
E-Mail Address Best phone number to call Best time to call Your Occupation Employer's Address City Zip  Phone ext.  Spouse Information or Parent information in case of minor  Name Occupation  Last Name, First Name Middle Name  Social Security Number  Employer's Address City Zip  Phone ext.  Person Financially Responsible: Relation to You  Children - Name - Age  Former Dentist Phone 1.  Physician Phone 2.  3.  Whom may we contact in case of emergency?  Relationship Phone Number # 1  Phone Number # 2  If patient referred then who referred you to us?  Insurance Carrier (Mr.) (Mrs.) Phone Group Number Union Local  Will you be requiring credit (financing) by our office for your dental care? (Please circle) Yes, No  I have read all information on both sides of this sheet and have completed the above questions. I certify this information is true and correct to the best of my knowledge.	Residence Address					
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Spouse Information or Parent information in case of minor Name	E-Mail Address	Best phone number to call Best time to call Best time to call				
Spouse Information or Parent information in case of minor Name	Your Occupation	]	Employer		Phone	
Spouse Information or Parent information in case of minor Name	Employer's Address				City	Zip
Name	Phone			ext		
Name	Spouse Information or	· Parent inform	nation in c	ase of mi	nor	
Social Security Number Birth Date Zip Phone ext ext Relation to You Children - Name - Age Children - Name - Age Phone 1 Phone 2 3						
Social Security Number Birth Date Zip Phone ext ext Relation to You Children - Name - Age Children - Name - Age Phone 1 Phone 2 3	Last Name,	First Name N	Middle Name			
Person Financially Responsible: Relation to You						
Person Financially Responsible: Relation to You	Employer's Address			C	itv	Zip
Children - Name - Age  Former Dentist Phone 1	Phone			ext		_ r
Children - Name - Age  Former Dentist Phone 1	Person Financially Respons	ible·			Relation to You	
Physician Phone 2.  Whom may we contact in case of emergency?  Relationship Phone Phone Phone Number # 1 Phone Number # 2  How did you hear about this office? (Please Circle) Phone Book, Sign, Ad, Other If patient referred then who referred you to us?  Insurance Carrier (Mr.) (Mrs.) Phone Group Number Union Local Will you be requiring credit (financing) by our office for your dental care? (Please circle) Yes, No  I have read all information on both sides of this sheet and have completed the above questions. I certify this information is true and correct to the best of my knowledge.	Terson I manerary respons			·		
Physician Phone 2			Child	ren - Name	e - Age	
Physician Phone 2						
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Relationship Phone Number # 1 Phone Number # 2 How did you hear about this office? (Please Circle) Phone Book, Sign, Ad, Other If patient referred then who referred you to us? Phone Phone	***	. •				
How did you hear about this office? (Please Circle) Phone Book, Sign, Ad, Other				Phone N	Tumber # 1	
How did you hear about this office? (Please Circle) Phone Book, Sign, Ad, Other	retationship			Dhone Number # 2		
Insurance Carrier (Mr.) (Mrs.) Phone Union Local Will you be requiring credit (financing) by our office for your dental care? (Please circle) Yes, No  I have read all information on both sides of this sheet and have completed the above questions. I certify this information is true and correct to the best of my knowledge.				r none r	Number # 2	
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Signature (Parent if miner)						ove questions.
	Signature (Parent if minor)				Date	