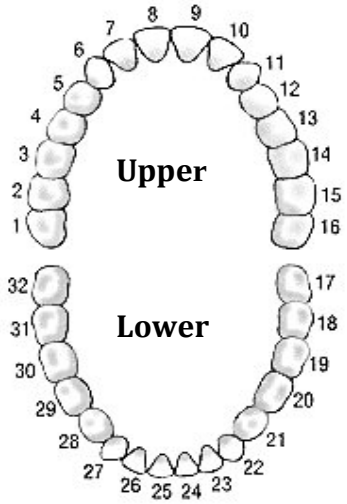
BERNAL DENTAL GROUP
THE BEST DENTAL CARE IN LOS ALGODONES

Patient Questionnaire

Name: _____ **Date:** _____
Age: _____ **Mailing Address:** _____
Phone: _____ _____
Referred by: _____ **Occupation:** _____
SS#: _____

DO YOU HAVE?

Diabetes: _____
High Blood Pressure: _____
Cancer: _____
Lung Cancer: _____
Heart Disease: _____
Hemorrhage Disease _____
Hepatitis B _____
AIDS _____
Transfusions: _____
Are you pregnant: _____
Allergies: _____
_____
Last Dental Checkup: _____
Other: _____



Treatment

_____
_____
_____
_____

Tooth	*Treatment*	*Fee*

Reason for your visit: _____
_____
_____

I accept the dental estimate made and I am aware of the need to come back every six months for a routine checkup. That way my warranty will be effective. All dental work is guaranteed because we use the best labs. But there is no money back.

Signature: _____ **Date:** _____
Doctor: _____ **Insurance:** _____

ems 3/16/09