Gregory J. Moegling, D.D.S.

General Dentistry

Patient Information

☐ New Patient

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us - we will be happy to help.

Whom may we thank for referring you? _____

About You

Name: _____ I prefer to be called_____ [ ] Male [ ] Female

[ ] Single [ ] Married [ ] Child [ ] Other Birth date: ___/___/___ Age: _____ S.S. #: _____

Home Address: _____ City_____State____Zip_____

Home Phone: (____) _____ Work: (____) _____ ext. ___ Pager: (____) _____

Cell: (____) _____ E-mail Address: _____

Employer: _____ How long there? _____ Occupation: _____

Employer's Address: _____ City_____ State_____ Zip_____

Person Responsible For Account

[ ] Same as above Name: _____ Birth date:___/___/___ Relation: _____

Billing Address: _____ City_____State____Zip_____

Home Phone: (____) _____ Work: (____) _____ S.S. #: _____

Employer: _____ How long there? _____ Occupation:_____

Spouse Information

[ ] Same as above Name: _____ Birth date: ___/___/___

Employer: _____ Work Phone: (____) _____ ext. _____

Dental Insurance Information

Primary Insurance

Insurance Co. Name: _____ Phone: (____) _____ Group/Policy #: _____

Insured's Name: _____ Insured's Birth date: ___/___/___ Relation: _____

Insured's Social Security #: _____ Insured's Employer: _____

Secondary Insurance

Insurance Co. Name: _____ Phone: (____) _____ Group/Policy #: _____

Insured's Name: _____ Insured's Birth date: ___/___/___ Relation: _____

Insured's Social Security #: _____ Insured's Employer: _____