TMJ Sleep Apnea Clinic

Patient Questionnaire

Referred by: _____ Phone (_____) _____-_____

Patient Information

Date: _____

Name: _____ SS#_____ Male or Female

Address: _____ State: _____ Zip Code: _____

Home: (_____) _____-_____ Work (_____) _____-_____

Date of Birth: _____ Marital Status: _____ Email: _____

Emergency Information

In Case of Emergency Notify: _____

Phone: (_____) _____-_____ Relationship: _____

Employment Information

Employer: _____ Phone: (_____) _____-_____

Address: _____ State: _____ Zip code: _____

Insurance Information

Insurance Company: _____ Insurance Phone #: _____

Policy Holder: _____ Policy #: _____

Group #: _____ Policy Holder's Date of Birth: _____/_____/_____

Secondary Insurance Information

Insurance Company: _____ Insurance Phone #: _____

Policy Holder: _____ Policy #: _____

Group #: _____ Policy Holder's Date of Birth: _____/_____/_____

Medical and Dental Information

Primary Care Provider _____ Phone: (_____) _____-_____

Dental Provider _____ Phone: (_____) _____-_____