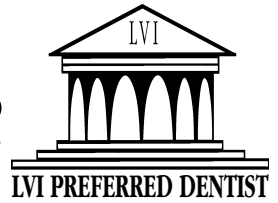




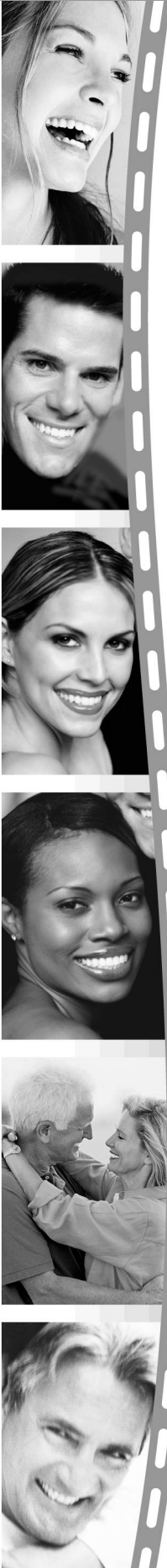
Cosmetic,
Reconstructive &
Neuromuscular
Dentistry

IRA D. KOEPPPEL DDS



"Changing Lives... One Smile at a Time"

GET ACQUAINTED QUESTIONNAIRE



Date: _____

Patient's Name: _____ Title: Mr. _____ Mrs. _____ Dr. _____ Ms. _____

Preferred Name: _____ Birthdate: __/__/__ Age: _____ Sex: M / F

Marital Status: _____ Home Address: _____

Mailing Address: (if different) _____

Home Phone No: () _____ S. S.# _____

Cell Phone No: () _____

E-MAIL Address: _____

Who may we thank for referring you? _____

Employer: _____ Occupation: _____

Business Address: _____ Phone #: () _____

Spouse's Name: _____ Birthdate: __/__/__ Age: _____ Phone #: () _____

Address: (if different) _____ S.S. # _____

Spouse's Employer: _____

Work Phone #: () _____ Cell Phone No: () _____

Spouse's Business Address: _____

Person to call in case of Emergency:

Name: _____

Work Phone #: () _____ Cell Phone No: () _____

Who is responsible for this account: _____