



**goldstein
garber
& salama**

RONALD E. GOLDSTEIN, D.D.S
MAURICE A. SALAMA, D.M.D.
DAVID A. GARBER, D.M.D.
ABTIN SHAHRIARI, D.M.D.

TONI SALAMA, DDS
MARIA PARANHOS, DDS
MARCELO SILVA, DDS
MARKO TADROS, DMD

GET ACQUAINTED QUESTIONNAIRE

DATE _____

IN ORDER THAT WE MAY BETTER SERVE YOU, PLEASE COMPLETE IN FULL

Patient's Name _____ Birthdate ____ / ____ / ____

Marital Status ____ M ____ S ____ D Social Security No. _____ Residence Phone: _____

Residence Address _____
Street & No. Apt. No. City State Zip

If less than one year, please give previous address.

Previous Address _____
Street & No. Apt. No. City State Zip

Patient's Email Address: _____

Employer _____ Occup. _____ Position _____

Business Address _____ How Long _____

Business Phone _____ Fax Number _____ Other Numbers (mobile, cell, pager) _____

Spouse Name _____ Soc. Sec. _____

Employer _____ Occup. _____ Position _____

Business Address _____ How Long _____

Business Phone _____ Fax Number _____ Other Numbers (mobile, cell, pager) _____

Emergency Contact (not living with you) _____

Address _____ Phone _____

Person Responsible for Payment of Account _____ Phone _____

Address _____
Street & No. Apt. No. City State Zip

Form of Payment:

Cash _____ Credit Card _____ Check _____

Former Dentist _____ Date of last visit _____

Names & Ages of Children _____

Schools Attending _____

How did you hear about our office: _____

*** FEES MUST BE RECEIVED TWO WEEKS PRIOR TO TREATMENT IN ORDER TO RESERVE A TIME SCHEDULE FOR YOU. (THE ABOVE DOES NOT APPLY TO ORTHODONTIC TREATMENT.)

For your benefit, a thorough examination, frequently including dental X-Rays and diagnostic models of your mouth, are necessary before an intelligent and efficient analysis of your dental problems can be made. Our treatment co-ordinator will advise you of the fee for these services.

SIGNATURE: _____