

Sullivan
ORTHODONTICS



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PATIENT ACQUAINTANCE QUESTIONNAIRE

Patient's Name _____

Nickname _____ Birthdate _____ Age _____

Home Phone _____ Work Phone _____

Address _____ Zip _____

E-Mail Address _____

Referred by _____

Patient's Dentist _____ Physician _____

What is the patient's main concern? _____

Names and ages of siblings _____

Patient's school _____

Favorite sports, hobbies _____

Musical instruments? _____

Do you have any pets? _____