# *Welcome!*

The benefits of a happy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

---

Today's date ________________________________

**Name** ____________________________________

I prefer to be called ___________________________

Birthdate ___________________________________

Marital Status _______________________________

SSN ________________________________________

**Home address**_______________________________

City/State/Zip _______________________________

Home phone _________________________________

Cell phone ___________________________________

Work phone __________________________________

E-mail ______________________________________

Employer____________________________________

**Person responsible for account** _________________

Employer ____________________________________

Home phone _________________________________

Business phone_______________________________

**Emergency contact**___________________________

Name _______________________________________

Address _____________________________________

City/State/Zip _______________________________

Home phone _________________________________

Business phone _______________________________

**Where and when are the best times to reach you?**

_____________________________________________

**Who may we thank for referring you?**

_____________________________________________

**Other family seen by us** _______________________

**Previous dentist's name** _________________

Address _________________________________

City/State/Zip ____________________________

Phone ___________________________________

**For patients with dental insurance:**

**Primary Dental Insurance**_________________

Employer ________________________________

Insurance company name ________________

Insurance company address _______________

_________________________________________

Insurance company phone ________________

Group # (plan, local, or policy #) ___________

Insured's name ___________________________

Relation__________________________________

Insured's birthdate_______________________

Insured's SSN_____________________________

Insured's Address_________________________

**Secondary Dental Insurance**______________

Employer_________________________________

Insurance company name__________________

Insurance company address________________

_________________________________________

Insurance Company phone_________________

Group #__________________________________

Insured's name____________Relation ______

Insured's birthdate_______________________

Insured's SS#_____________________________

Insured's address_________________________

# *Medical History*

Name ________________________________Birthdate________________

Please "X" the appropriate box. Use the space at right for any explanations necessary.

YES NO

☐ ☐ Are you under the care of a physician? Please explain _______________________________________

Physician's name and phone number_______________________________________________________

☐ ☐ Are you currently taking any medications? ____________________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

☐ ☐ Do you have allergies to any medications? (Penicillin, codeine, etc.)______________________________

_________________________________________________________________________________

☐ ☐ Do you have any other allergies? _______________________________________________________

☐ ☐ Have you been treated for heart related conditions, or high blood pressure? ________________________

_________________________________________________________________________________

☐ ☐ Do you have any artificial joints, prosthesis, or heart related insert? ___________________________

☐ ☐ Do you have hepatitis, or tested HIV positive? ______________________________________________

☐ ☐ Have you had radiation treatments, or chemotherapy? __________________________________________

_________________________________________________________________________________

☐ ☐ Have you experienced any complications in healing? __________________________________________

☐ ☐ Do you use any type of tobacco products? Type? _____________________________________________

How often? ________________________________________________________________________

Check the items below that you have had.

☐ Blood disease (stroke, hemophilia, etc.)
☐ Nervous Disorders
☐ Respiratory Disorders
☐ Arthritis or Rheumatism
☐ Stroke
☐ Chronic Ear Infection
☐ Tuberculosis
☐ Epilepsy of Seizure Disorder
☐ Tumors or growths
☐ Serious Head Injury
☐ Diabetes
☐ Other – Explain Below

Any details regarding the above conditions, or any others? _________________________________________

_________________________________________________________________________________

_________________________________________________________________________________

Would you like to speak to Dr. Wolf privately about any medical issues? ____________________________

**Are you in good health at this time?** **YES NO** (please circle)

**Patient Signature**_____________________________________________

Please review the health history regular intervals. Please use a new form if there are significant changes.

| | | |
|---|---|---|
| | | |
| | | |
| | | |