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.)	☐ Stroke	☐ Tumors or growths
☐ Nervous Disorders	☐ Chronic Ear Infection	☐ Serious Head Injury
☐ Respiratory Disorders	☐ Tuberculosis	☐ Diabetes
☐ Arthritis or Rheumatism	☐ Epilepsy of Seizure Disorder	☐ 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.
