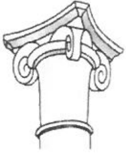

Parker Road
DENTAL CARE
William E. Wolf, D.D.S.

PATIENT INFORMATION

Last name ______________________ First ______________________ Middle Initial ________

Address ____

City ______________________ State ____________ Zip Code ____________

Date of Birth ____________ Sex: Male/Female Marital Status (circle one): Married Single Widowed

Home Phone ____________ Business Phone ____________ Cell Phone ____________

Social Security Number ______________ E-mail address______________________

Employer ____

Employer Address ____

Person Responsible for Account (if different than patient)

Name ______________________________ Relationship to patient ____________

Social Security Number ______________________ Date of Birth ____________

Home Phone ____________ Business Phone ____________ Cell Phone ____________

Address ____

Dental Insurance Information

Policy Holder's Name ______________________________ Date of Birth ____________

Social Security Number or Member ID# of the Policy Holder ______________________

Name of Insurance Carrier ______________________ Phone Number ____________

Employer/Group Name ______________________Group /Policy # ____________

Person to contact in an emergency ______________________ Relationship ____________

Home Phone ____________ Business Phone ____________ Cell Phone ____________

Whom may we thank for referring you to our practice? ______________________

Has any other family member been treated in our office? If so, whom? ______________________

What are some of your hobbies, interests, etc? ______________________

1253 COMMERCIAL DRIVE, SW . SUITE B . CONYERS, GA 30094 . PH:770.922.9932 . FAX: 770.929.0705
WEBSITE: WWW.WILLIAMWOLFDDS.COM EMAIL: WILLIAMWOLFDDS@YAHOO.COM

Previous Dentist's Name ______________________ Office Phone ______________________

Date of your last dental visit? ______________________ Were x-rays taken? ______________________

How many times per day do you: brush? __________ Floss? __________ Other? __________

Are your teeth sensitive to hot, cold, sweets or pressure? ______________________

Do your gums bleed when you brush or floss? ______________________

Does food or floss catch between your teeth? ______________________

Do you have dry mouth? ______________________

Have you had any periodontal (gum) treatments? ______________________

Have you ever had orthodontic (braces) treatment? ______________________

Have you had any problems associated with previous dental treatment? ______________________

Have you ever had nitrous oxide sedation (gas)? ______________________

Is your home water supply fluoridated? ______________________

Do you have earaches or neck pain? ______________________

Do you have any clicking or popping or discomfort in the jaw? ______________________

Do you brux or grind your teeth? ______________________

Do you have ulcers or sores in your mouth? ______________________

Do you wear partials or dentures? ______________________ ______________

Have you ever had a serious injury to your head or mouth? ______________________

Are you currently experiencing dental pain or discomfort? ______________________

What is the reason for your dental visit today? ______________________

If there was something about your smile you could change, what would it be? ______________________

Physician's Name ______________________ Office Phone ______________

Physician's Address ______________________

Are you in good health? ______________________

Any change in your general health or have you had any surgeries within the past year? If so, please state.

____

Are you currently under the care of a physician? ________ If yes, what condition is being treated?

____

Are you currently taking any prescription medication, over the counter medication, vitamins, herbal or dietary supplements? I so, please list them here. ______________________

____

Are you allergic to or made sick by penicillin or other antibiotics; codeine or other narcotics; sulfa drugs; barbiturates, sedatives, or sleeping pills; aspirin; local anesthetics or latex (rubber)? If so, please specify below.

____

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? __________ Date: __________

Have you had any surgical plates, pins, or screws placed? ______________ Date: __________

Do you smoke or use smokeless tobacco? ______________________

Women: Are you pregnant? _______ Obstetrician's Name ______________ Due Date: ________

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT

Prolonged bleeding	Emphysema	HIV Positive
Heart Disease/Attack	Cough & Chronic Bronchitis	AIDS
Angina Pectoris	Tuberculosis (TB)	Hepatitis A (infectious)
Mitral Valve Prolapse	Asthma	Hepatitis B (serum)
High Blood Pressure	Hay Fever	Liver Disease
Heart Murmur	Sinus Trouble	Yellow Jaundice
Rheumatic Fever	Allergies or Hives	Blood Transfusion
Congenital Heart Failure	Diabetes	Drug Addiction
Scarlett Fever	Thyroid Disease	Hemophilia
Artificial Heart Valve	Cancer or Tumor	Venereal Disease
Heart Pacemaker	X-Ray or Cobalt Treatment	Cold Sores
Heart Surgery	Chemotherapy	Genital Herpes
Heart Stent	Radiation	Epilepsy or Seizures
Anemia	Arthritis	Fainting or Dizzy Spells
Stroke	Rheumatism	Ulcers
Kidney Disease	Cortisone Medicine	Psychiatric Treatment
Dialysis	Glaucoma	Eating Disorder
Dental Implants	Bruise Easily	Sickle Cell Disease

Do you have a disease, condition or problem not listed? ______________________

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed necessary by the doctor to make a thorough diagnosis of the dental needs for

   ______________________________________ .

   (Name of patient)

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and the doctor and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risk. I understand that I can ask for a complete recital of any possible complications.

4. I acknowledge that I have seen and read a copy of the "Notice of Privacy Practices" for William E. Wolf, D.D.S.

5. I acknowledge that there will be a **$50.00** fee imposed for all appointments canceled without **24 hours** notice.

6. **I acknowledge that insurance is filed on my behalf, as a courtesy, and that I am responsible for all charges not covered by insurance.**

7. **I acknowledge that there will be a 3% convenience fee applied when using a credit/debit card for payment and I may avoid fees by paying with either cash or check.**

Note:

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian:

______________________________ Date: ______________________________

Please print name:

______________________________ Relationship to patient: ____________________