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

PATIENT INFORMATION

Last Name________________ First________________ Middle Initial________

Address________________________________

City/State________________________ Zip________________

Date of Birth________________ Marital Status: ☐ Married ☐ Unmarried ☐ Widowed

Home Phone________________ Business Phone________________

Social Security Number________________ Employer________________

Employer Address________________________________

Length of Employment________________________________

Person Responsible For Account (If Different Than Patient)

Name________________ Address________________

Employer________________ Business Phone________________

Employer Address________________________________

Length of Employment________________________________

DENTAL INSURANCE INFORMATION

Name of Insurance Company________________________________

Group of Policy #________________ Phone Number________________

Policy Holder's Name________________ D.O.B.________________

Social Security Number of Policy Holder________________________________

Employer of Policy Holder________________________________

Person to Contact in an Emergency________________________________

Relationship________________ Home Phone________________ Business Phone________________

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

Mailer________________ Location________________ Other________________

Has any other family member been treated in our office?________________

What are some of your hobbies, interests, etc.?________________

1253 COMMERCIAL DRIVE • SUITE B • CONYERS, GEORGIA 30094 • PH.: 770-922-9932 • FAX: 770-929-0705

DENTAL HISTORY

Have you been having any specific dental problems or concerns, such as sores in your mouth, or problems with your teeth?____________________

Date of last dental visit?__________ Do your gums bleed?__________

How many times per day do you: brush?________ floss?________ other?________

Are you troubled with bad breath?____________________

Have you noticed shifting teeth?____________________

Tooth sensitivity to hot or cold?____________________

Any unusual reaction during previous dental treatments?____________________

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

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

MEDICAL HISTORY

Medical doctor's name?____________________

Are you in good health?____________________

Any change in your general health within the past year?____________________

Currently under treatment of a physician?____________________

Currently taking medication of any kind? (list)____________________

Are you allergic or made sick by penicillin, codeine or any other medications?____________________

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

Prolonged Bleeding
Heart Disease
Angina Pectoris
Mitral Valve Prolapse
High Blood Pressure
Heart Murmur
Rheumatic Fever
Congenital Heart Lesions
Scarlet Fever
Artificial Heart Valve
Heart Pacemaker
Heart Surgery
Joint Replacement
Anemia
Stroke
Kidney Trouble
Dialysis
Implants

Emphysema
Cough & Chronic Bronchitis
Tuberculosis (TB)
Asthma
Hay Fever
Sinus Trouble
Allergies or Hives
Diabetes
Thyroid Disease
Cancer or Tumor
X-ray or Cobalt Treatment
Chemotherapy
Arthritis
Rheumatism
Cortisone Medicine
Glaucoma
Periodontal Disease
Pain in Jaw Joints

HIV Positive
AIDS
Hepatitis A (infectious)
Hepatitis B (serum)
Liver Disease
Yellow Jaundice
Blood Transfusion
Drug Addiction
Hemophilia
Venereal Disease
Cold Sores
Genital Herpes
Epilepsy or Seizures
Fainting or Dizzy Spells
Ulcers
Psychiatric Treatment
Sickle Cell Disease
Bruise Easily

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

Women: Are you pregnant now?__________ Due Date?__________

Do you smoke or use smokeless tobacco?____________________

Consent For Treatment

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of (name of patient) ________________________________'s dental needs.

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me 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. Lastly, I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered, use of this signature on all insurance admissions, and for the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance. I also understand that should my account be turned over to an outside collection agency, I will be responsible for all collection fees.

Signature ____ Date________________________________