

INSURANCE INFORMATION

Date _____ Phone # _____

Patient Name _____

Primary Insured _____
parent name

SS # _____ Employee DOB _____

ID # _____

Employer _____

Insurance Carrier _____

Ins. Co. Address _____

Ins. Co. Phone # _____ Plan/Group # _____

Please fill out the following if you have secondary insurance:

Secondary Insured _____
parent name

SS # _____ Employee DOB _____

ID # _____

Employer _____

Insurance Carrier _____

Ins. Co. Address _____

Ins. Co. Phone # _____ Plan/Group # _____

EDWARD N. WOLF, D.D.S.

PATIENT REGISTRATION AND HISTORY

DATE _____

NAME _____ DATE OF BIRTH _____

IF CHILD, PARENT'S NAME _____

ADDRESS _____

(Street)

PHONE (Home) _____

(Business) _____

(Cell) _____

Check preferred number to call for your appointment confirmation

(City) (State) (Zip)

PLACE OF EMPLOYMENT _____ EMAIL _____

SPOUSE'S NAME _____

SPOUSE'S PLACE OF EMPLOYMENT _____

PERSON RESPONSIBLE FOR PAYMENT _____ RELATIONSHIP _____

RESPONSIBLE PERSON'S SOCIAL SECURITY # _____

DO YOU HAVE DENTAL INSURANCE? Yes No

BILLING ADDRESS (IF OTHER THAN PATIENT):

(Street)

PHONE (Home) _____

(City)

(State)

(Zip)

(Business) _____

EMPLOYER _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

OTHER FAMILY MEMBERS THAT ARE PATIENTS HERE _____

EMERGENCY CONTACT INFO _____ PHONE _____

(Name)

(Relation)

MEDICAL HISTORY

Please circle YES or NO for the following questions. Your answers are for our records only and will be considered confidential.

NAME OF PHYSICIAN _____

ARE YOU IN GOOD HEALTH? YES NO

ARE YOU UNDER PHYSICIAN'S CARE NOW? YES NO

HAVE YOU HAD ANY SERIOUS ILLNESS, OPERATION, OR BEEN HOSPITALIZED IN THE PAST 5 YEARS?..... YES NO

If so, what was the illness or problem? _____

HAVE YOU HAD ANY ALLERGIC OR ADVERSE RESPONSE TO ANY DRUGS? YES NO

DO YOU HAVE ANY ALLERGIES TO ANY METALS? YES NO

DO YOU HAVE ANY ALLERGIES TO LATEX? YES NO

DO YOU HAVE OR HAVE YOU EVER HAD ANY OF THE FOLLOWING?

Heart Ailment..... YES NO

High Blood Pressure..... YES NO

Damaged or Artificial Heart Valve..... YES NO

Rheumatic Fever YES NO

Artificial Joints YES NO

Respiratory Disease YES NO

Diabetes YES NO

Arthritis YES NO

Tumors or Growths..... YES NO

Thyroid Problems YES NO

Blood Disease or Abnormal Bleeding YES NO

Liver Disease YES NO

Kidney Disease..... YES NO

Stomach or Intestinal Disease..... YES NO

Sexually Transmitted Disease YES NO

A.I.D.S. or H.I.V. Infection..... YES NO

Hepatitis or Jaundice YES NO

Tuberculosis YES NO

(OVER)

ARE YOU TAKING ANY MEDICATIONS? IF YES, PLEASE LIST	YES	NO

HAVE YOU HAD ANY COMPLICATIONS WITH WOUNDS HEALING?.....	YES	NO
ARE YOU PREGNANT?.....	YES	NO
DO YOU TAKE ORAL CONTRACEPTIVES?.....	YES	NO
DO YOU HAVE A HISTORY OF FAINTING?.....	YES	NO
HAVE YOU HAD RADIATION TREATMENTS (OTHER THAN DIAGNOSTIC)?	YES	NO
DO YOU HAVE ANY DISEASE OR PROBLEM I SHOULD KNOW ABOUT?.....	YES	NO
If so, what?		
DO YOU WEAR CONTACT LENSES?	YES	NO

DENTAL HISTORY

DO YOU HAVE DISCOMFORT IN OR NEAR YOUR EARS?	YES	NO
ARE YOU AWARE OF MUSCLE SORENESS IN YOUR JAW OR SIDE OF YOUR HEAD?.....	YES	NO
HAVE YOU EXPERIENCED ANY GROWTHS OR SORE SPOTS IN YOUR MOUTH?	YES	NO
DO YOU HAVE ANY INFLAMED AREAS IN OR AROUND YOUR MOUTH?.....	YES	NO
HAVE YOU EVER HAD "NOVOCAINE" ANESTHETIC?	YES	NO
HAVE YOU HAD ANY ALLERGIC RESPONSE TO "NOVOCAINE" ANESTHETIC?	YES	NO
HAVE YOU HAD ANY PROLONGED BLEEDING FOLLOWING EXTRACTIONS?	YES	NO
DO YOUR GUMS BLEED?.....	YES	NO
HAVE YOU HAD INSTRUCTIONS ON CARE OF YOUR TEETH AND GUMS?.....	YES	NO
DO YOU CHEW ON ONLY ONE SIDE OF YOUR MOUTH?.....	YES	NO
If so, why?		

HAVE YOU HAD ANY SERIOUS TROUBLE ASSOCIATED WITH ANY PREVIOUS DENTAL TREATMENT?.....	YES	NO
If so, explain.		

DO YOU HAVE ANY DENTAL COMPLAINTS?.....	YES	NO

WHEN WAS YOUR LAST FULL MOUTH X-RAY TAKEN? _____ WHERE _____

HOW DO YOU FEEL ABOUT YOUR TEETH? _____

DO YOU HAVE ANY FEARS ABOUT DENTISTRY? _____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status.

SIGNATURE _____ DATE _____

REVIEWED BY _____ DATE _____

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

SIGNATURE _____ DATE _____

EDWARD N. WOLF, D.D.S.

MEDICAL HISTORY & REGISTRATION UPDATE

NAME _____ DATE _____

CURRENT ADDRESS _____

EMERGENCY CONTACT INFO _____ PHONE _____
(name) (relation)

HAS THERE BEEN ANY CHANGE IN YOUR MEDICAL STATUS?..... YES NO

DO YOU HAVE OR HAVE HAD ANY OF THE FOLLOWING?

- | | | |
|------------------------------------|-----|----|
| Heart Disease | YES | NO |
| High Blood Pressure | YES | NO |
| Diabetes..... | YES | NO |
| Rheumatic Fever..... | YES | NO |
| Kidney Disease | YES | NO |
| Liver Disease | YES | NO |
| A.I.D.S. or H.I.V. Infection | YES | NO |

DO YOU HAVE ANY ARTIFICIAL JOINTS YES NO

DO YOU HAVE ANY DAMAGED OR ARTIFICIAL HEART VALVES? YES NO

DO YOU HAVE ANY DRUG ALLERGIES?..... YES NO

Please list _____

ARE YOU ALLERGIC TO ANY METALS? YES NO

ARE YOU ALLERGIC TO LATEX? YES NO

ARE YOU PREGNANT?..... YES NO

ARE YOU TAKING ANY MEDICATIONS? YES NO

Please list _____

IS THERE ANYTHING ELSE I SHOULD KNOW ABOUT YOUR MEDICAL STATUS? YES NO

If so, what _____

SIGNATURE _____ DATE _____

REVIEWED BY _____ DATE _____

SIGNATURE _____ DATE _____

REVIEWED BY _____ DATE _____

SIGNATURE _____ DATE _____

REVIEWED BY _____ DATE _____

SIGNATURE _____ DATE _____

REVIEWED BY _____ DATE _____

SIGNATURE _____ DATE _____

REVIEWED BY _____ DATE _____

SIGNATURE _____ DATE _____

REVIEWED BY _____ DATE _____