**BILL WOLFE, D.D.S., PA**

**3915 BRISTOL HWY, SUITE 103**

**JOHNSON CITY, TN. 37601**

**(423)461-0073**

**Patient Information:**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_

SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Please circle one: Male Female

Emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone or daytime #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL HISTORY:**

Reason for today’s visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last dental x-rays: \_\_\_\_\_\_\_\_\_\_

**Please circle if applicable:**

**Bad breath Bleeding gums Pain around ear burning sensation on tongue**

**Smoking Blisters on lips Jaw pain Swollen/tender gums**

**Grinding Mouth breathing Clicking/popping jaw Food collects between teeth**

**Mouth Pain Dry Mouth Neck Pain Chew on one side of mouth**

**Sores/Growths Headaches Sleep Apnea Orthodontic treatment**

**Loose teeth or broken fillings Sensitivity: pressure/sweets/hot/cold**

**Medical History:**

**Physician’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of last visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Do you have or have you ever had the following?**

**AIDS/HIV Epilepsy Respiratory Disease Anemia Fainting or Dizzy Spells**

**Arthritis Rheumatism Glaucoma Scarlet Fever Artificial Heart Valves**

**Artificial Joints Heart Murmur Sinus Trouble Asthma Shortness of breath**

**Heart Problems Skin Rash Back Problems Special Diet Hepatitis Type: \_\_\_\_\_\_**

**Herpes Stroke Blood Disease Jaundice High Blood Pressure**

**Cancer Jaw Pain Thyroid Problem Ulcer Diabetes**

**Tonsillitis Chemotherapy Kidney Disease Pacemaker Chemical Dependency**

**Liver Disease Tuberculosis Low Blood Pressure Weight Loss Emphysema**

**VD/STD Tumors/growth Cortisone treatment Cough Mitral Valve Prolapse**

**Psychiatric care Radiation Treatment Rheumatic Fever Nervous Problems Circulatory Problems**

**Bleeding abnormally Swollen feet/ankles/neck glands Congenital Heart Problems Contact lenses: Yes – No**

**Current medication and purpose: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Patient Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**