Dental Registration and History for Dr. Bill Wolfe

Patient Information:

Name:_____ DOB:_____

Address:_____ City:_____ State:_____ ZIP:_____

Phone:_____ SS#:_____ Email Address:_____

Please circle one: Male Female Emergency contact:_____ Phone:_____

Insurance Information:

Subscriber's Name:_____ DOB:_____ Subscriber's SS#:_____

Patient's relationship to subscriber:_____ Name of Dental Insurance:_____

Group Number:_____ Address:_____ City:_____ State:_____ Zip:_____

Insurance Phone Number:_____

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	Chew on one side of mouth
Smoking	Fingernail biting	Headaches	Orthodontic treatment	Food collection between teeth
Grinding	Blisters on lips	Jaw pain	Lip or cheek biting	Loose teeth or broken fillings
Mouth pain	Mouth breathing	Clicking/popping jaw	Swollen/tender gums	Sensitivity: pressure/sweets
Sores/growths	Dry mouth	Neck pain	Sleep apnea	Sensitivity: 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 Dizziness	Rheumatic Fever
Arthritis	Rheumatism	Glaucoma	Scarlet Fever	Artificial heart valves	Headaches
Artificial Joints	Artificial Joints	Heart Murmur	Sinus Trouble	Asthma	Shortness of breath
Heart Problems	Skin Rash	Back Problems	Special Diet	Hepatitis Type: _____	Bleeding abnormally
Herpes	Stroke	Blood Disease	Jaundice	High Blood Pressure	Swollen feet or ankles
Cancer	Jaw Pain	Thyroid Problem	Ulcer	Diabetes	Swollen Neck Glands
Tonsillitis	Chemotherapy	Kidney Disease	Pacemaker	Chemical Dependency	Circulatory Problems
Liver Disease	Tuberculosis	Low Blood Pressure	Weight Loss	Emphysema	Congenital Heart problems
Cough	Tumors/growth	Cortisone treatment	Pacemaker	Mitral Valve Prolapse	Nervous Problems
VD/STD	Psychiatric Care	Radiation Treatment	Contact lenses: Yes -- No		Nursing: Yes -- No
Birth Control pills: Yes -- No		Pregnant: Yes, Due:_____ -- No			

Name of Pharmacy: _____ Phone Number:_____

Current medications and purpose:_____

_____

_____

Do you have any allergies?

Aspirin	Penicillin	Codeine
Iodine	Latex	Nitrous Oxide/ Local Anesthetic

Other:_____