GARY G. WOLFSON, DDS, PLLC

Family & Cosmetic Dentistry

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Patient Information

Please take a moment to enter or update your information to help us ensure the quality of your care is excellent.

Patient Name: _____ (Last) _____ (First) _____ (MI) _____ (Preferred Name)

Title: _____ (Mr/Ms/Mrs/etc) Gender: ◯ Male ◯ Female Family Status: ◯ Married ◯ Single ◯ Child ◯ Other

Birth Date: _____ Age: _____ Email Address: _____

Phone: _____ (Home) _____ (Work) _____ (Ext) _____ (Mobile) Best time to call: _____

Address: _____

_____ (City) (State) (Zip Code)

Social Security # :

_____

Whom may we thank for referring you to our practice?

☐ Patient ☐ Dental Office ☐ Internet ☐ Insurance List

☐ School ☐ Work ☐ Other:

Name of person, office, or other source referring you to our practice:

_____

_____

SPOUSE INFORMATION OR RESPONISBLE PERSON FOR CHILD

The following is for: ◯ Patient's Spouse ◯ Person Responsible For Child

Name:_____
Last First Preferred Name

Address: _____

_____
City State Zip

Phone #: (_____)_____ (_____)_____
Home or Mobile Work

Gender: ◯ Male ◯ Female Status: ◯ Married ◯ Single

Date of Birth: _____/_____/_____ Email Address:_____

EMPLOYMENT INFORMATON

For: ◯ Patient ◯ Spouse ◯ Person Responsible For Child

Employer's Name: _____

Address: _____

_____
City State Zip

Work Phone #: (_____)_____

EMERGENCY CONTACT INFORMATION

Name: _____
Last First Relationship

Address: _____

_____
City State Zip

Phone #: (__ ___)_____ (_____)_____
Home or Mobile Work

Primary Insurance Information

Primary Dental Insurance:

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ _____ _____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: _____

Insurance Address: _____

_____ _____ _____
City State Zip Code

Insurance Phone #: _____

Secondary Insurance Information

Secondary Dental Insurance:

Name of Insured: _____ _____ ____
Last First MI

Insured's Birth Date: _____ ID #. _____ Group #. _____

Insured's Address: _____ _____

_____ _____ _____
City State Zip Code

Insured's Employer Name: _____

Employer Address: _____ _____

_____ _____ _____
City State Zip Code

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child

Insurance Plan Name: _____

Insurance Address: _____

_____ _____ _____
City State Zip Code

Insurance Phone #: _____

Medical & Dental History Form

Patient Name: _____ _____ _____ _____
Last First MI Preferred Name

Date of Birth _____

Would you consider yourself to be in fairly good health?

◯ Yes ◯ No

Within the past year, have there been any changes in your general health?

◯ Yes ◯ No

What is the date (or approximate date) of your last medical exam?

_____

Your Primary Care Physician's name, address, & phone number:

_____

_____

Please mark any of the following to indicate **Yes** in response to the question:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Do you use tobacco (smoking or chewing)?

☐ Do you require the use of corrective lenses (contacts or glasses)?

☐ Are you currently taking any prescription or non-prescription medications? If so, please list below:

Please mark any of the following to indicate "YES" in response to the question

- O Have you ever had complication following dental treatment?
- O Do your gums bleed when you brush or floss?
- O Do your teeth experience sensitivity to hot and cold?
- O Are any of your teeth currently causing you pain?
- O Do you grind your teeth (either consciously or during sleep)?
- O Do you currently have any dental implants, dentures, or partial?

If you could change anything about your mouth, teeth, or smile, what would it be?_____

_____

Are you allergic to or have you reacted adversely to any of the following medication?

- O Aspirin
- O Local Anesthetic
- O Erythromycin
- O Other_____
- O Nitrous Oxide
- O Codeine
- O Penicillin
- O Latex

What is the reason for your dental visit day? _____

When was your last visit to the dentist (if at another office)? _____

What was done on your last dental visit (if at another office)? _____

Prior Dentist's name:_____

Address:_____

phone #: (_____)_____ Email:_____

How frequently do you brush your teeth:

O 3 x daily O 2 x daily O 1 x daily O Weekly O Seldon

How frequently do you floss you teeth?

O 1 x daily O 2 -6 x daily O 1-6 x monthly O Seldom O Never

WOMEN ONLY: Are you pregnant?

O Yes O No

To the best of my knowledge, all of the preceding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Signature:_____ Date: _____/_____/_____

AUTHORIZATION AND CONSENT FOR SERVICES

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I hereby consent and authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I also consent and authorize Dr. Wolfson to perform the dental treatment recommended for me. This treatment has been thoroughly explained and discussed with me and that I understand my dental treatment needs. I am aware that some changes in the plan may become necessary during the course of treatment, and that these changes will be explained so that they can proceed with my necessary treatment.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize my insurance carrier to submit payment directly to the dentist or dental practice which will be applied directly to any outstanding balance on my account.

I agree and understand the following information:

As a condition of treatment by this office, financial arrangement must be made in advance. The practice depends upon reimbursement from patients for the costs incurred in their care. Financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in full at the time of service unless other arrangements are made.

I understand that all dental services are charged directly to the patient and that I am personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Interest will apply for any balance over 60 days and I authorize Dr. Wolfson to obtain a credit report.

I understand and agree to pay any collection fees and all costs of reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your staff members to telephone me to discuss my account or my treatment.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient, parent, or guardian (responsible party)

_____ Date: ____/_____/_____

Relationship to patient: _____

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance, and I may be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on my behalf or on behalf of my dependents (if any).

Signature of patient, parent, or guardian:

Signature: _____ Date: _____

Relationship to Patient:

Response Date: _____