WOLFSON

GARY G. WOLFSON, DDS, PLLC

Family & Cosmetic Dentistry

14000 E. Arapahoe Rd. #C310
Centennial, CO. 80112
303-621-3622
wolfsondental@msn.com
www.wolfsondental.com

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)

Occupation: _____ Social Security # : _____

Whom may we thank for referring you to our practice?

☐ Patient ☐ Dental Office ☐ Internet ☐ Insurance List

☐ School ☐ Mailer ☐ 5280 Magazine ☐ Other

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

_____

_____

Spouse Information or Responsible Party Information For Child

The following is for: ◯ the patient's spouse ◯ the person responsible for payment ◯ neither-not applicable

Name: _____ _____ _____ _____
Last First MI Preferred Name

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

Birth Date: _____ Email Address: _____

Phone: _____ _____ _____ _____
Home Work Ext Mobile

Address: _____ _____

_____ _____ _____
City State Zip Code

Employment Information

The following is for: ◯ the patient ◯ the person responsible for payment

Employer Name: _____ Phone: _____

Address: _____

_____ _____ _____
City State Zip Code

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:

☐ 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 indicate if you have experienced any of the following:

- ☐ Pre Med
- ☐ Anemia
- ☐ Artificial Joints
- ☐ Back Problems
- ☐ Chemical Dependency
- ☐ Cough (Persistent)
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Nervous Problems
- ☐ Rapid Weight Gain/Loss
- ☐ Rheumatic/Scarlet Fever
- ☐ Skin Rash
- ☐ Surgical Implant Tobacco
- ☐ Habit
- ☐ Ulcer Colitis
- ☐ AIDS/HIV POS.
- ☐ Arthritis (Rheumatism)
- ☐ Asthma
- ☐ Blood Disease
- ☐ Circulatory Problems
- ☐ Cough Up Blood
- ☐ Fainting
- ☐ Headaches
- ☐ Hemophilia
- ☐ High Blood Pressure
- ☐ Liver Disease
- ☐ Pacemaker/Heart Surgery
- ☐ Radiation Treatment
- ☐ Shingles
- ☐ Spina Bifida
- ☐ Swelling of Feet or Ankles
- ☐ Tonsilitis
- ☐ Venereal Disease
- ☐ Anaphylaxis
- ☐ Artificial Heart Valves
- ☐ Atopic (Allergy Prone)
- ☐ Cancer
- ☐ Cortisone Treatments
- ☐ Diabetes
- ☐ Food Allergies
- ☐ Heart Murmur
- ☐ Herpes
- ☐ Jaw Pain
- ☐ Mitral Valve Prolaspe
- ☐ Psychiatric Care
- ☐ Respiratory Disease
- ☐ Shortness of Breath
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Other

Please explain if you have checked any of the above boxes:

Please initial if none of the above apply:

_____

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

- ☐ Have you ever had complications following dental treatment?
- ☐ Do your gums bleed when you brush or floss?
- ☐ Do your teeth experience sensitivity to hot or cold temperatures?
- ☐ Are any of your teeth currently causing you pain?
- ☐ Do you grind your teeth (either consciously or during sleep?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening?
- ☐ 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?

WOMEN ONLY: Are you pregnant?

◯ Yes ◯ No

If Yes, when is the due date? _____

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

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

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: _____

What is the reason for your dental visit today?

When was your last visit to the dentist (if to a different office)?

What was done on your last dental visit (if to a different office)?

Prior Dentist's name, address, & phone number:

How frequently do you brush your teeth?

◯ 3 (+) a day ◯ Twice a day ◯ Once a day ◯ Weekly ◯ Seldom

How frequently do you floss your teeth?

◯ 1 (+) a day ◯ 2 - 6 weekly ◯ 1-6 monthly ◯ Seldom ◯ Never

Consent for Services

As a condition of treatment by this office, financial arrangements 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 services are performed 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 authorize Dr. Wolfson to obtain a credit report.

I understand that any fee estimate for this dental care can only be extended for a period of 90 days from the date of diagnosis.

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):

Signature: _____ Date: _____

Relationship to Patient: _____

Response Date: _____

WOLFSON

GARY G. WOLFSON, D.D.S., P.L.L.C.

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: _____