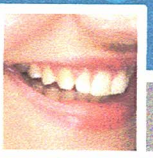
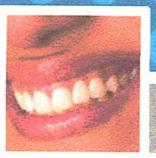
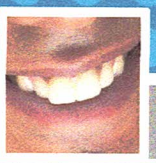
Gary G. Wolfson, D.D.S.
14000 E. Arapahoe Rd. #C-310
Centennial, CO 80112

(303)632-3622

wolfsondental@msn.com
www.wolfsondental.com

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:

_____

Gary G. Wolfson, D.D.S.
14000 E. Arapahoe Rd. #C-310
Centennial, CO 80112

(303)632-3622

wolfsondental@msn.com
www.wolfsondental.com

Please indicate if you have experienced any of the following:

- ☐ Pre Med
- ☐ Anemia
- ☐ Artificial Joints
- ☐ Back Problems
- ☐ Chemical Dependency
- ☐ Cough (Presistent)
- ☐ Epliepsy
- ☐ Glaucoma
- ☐ Heart Problems
- ☐ Hepatitis
- ☐ Kidney Disease
- ☐ Nervous Problesm
- ☐ 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
- ☐ Tonsillitis
- ☐ 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:

Gary G. Wolfson, D.D.S.
14000 E. Arapahoe Rd. #C-310
Centennial, CO 80112

(303)632-3622
wolfsondental@msn.com
www.wolfsondental.com

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_____

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

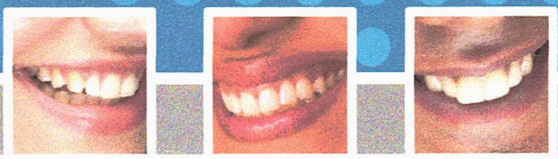
How frequently do you floss your teeth?

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

Gary G. Wolfson, D.D.S.
14000 E. Arapahoe Rd. #C-310
Centennial, CO 80112

(303)632-3622

wolfsondental@msn.com
www.wolfsondental.com



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

- ☐ 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?

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 detal appointment without fail.

Signature: _____ Date: _____

Gary G. Wolfson, D.D.S.
14000 E. Arapahoe Rd. #C-310
Centennial, CO 80112

(303)632-3622
wolfsondental@msn.com
www.wolfsondental.com

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: _____