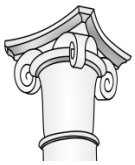

Parker Road
DENTAL CARE
William E. Wolf, D.D.S.
Kimberly A. Peters, D.M.D.

PATIENT INFORMATION **(1 OF 4)**

Last name _____ First _____ Middle Initial _____

Address _____

City _____ State _____ Zip Code _____

Date of Birth _____ Sex: Male/Female Marital Status (circle one): Married Single Widowed

Home Phone _____ Business Phone _____ Cell Phone _____

Social Security Number _____ E-mail address_____

Employer _____

Employer Address _____

Person Responsible for Account (if different than patient)

Name _____ Relationship to patient _____

Social Security Number _____ Date of Birth _____

Home Phone _____ Business Phone _____ Cell Phone _____

Address _____

Dental Insurance Information

Policy Holder's Name _____ Date of Birth _____

Social Security Number or Member ID# of the Policy Holder _____

Name of Insurance Carrier _____ Phone Number _____

Employer/Group Name _____Group /Policy # _____

Person to contact in an emergency _____ Relationship _____

Home Phone _____ Business Phone _____ Cell Phone _____

Whom may we thank for referring you to our practice? _____

Has any other family member been treated in our office? If so, whom? _____

What are some of your hobbies, interests, etc? _____

William E. Wolf, D.D.S.
Kimberly A. Peters, D.M.D.

Dental History

Previous Dentist's Name _____ Office Phone _____

Date of your last dental visit? _____ Were x-rays taken? _____

How many times per day do you: brush? _____ Floss? _____ Other? _____

Are your teeth sensitive to hot, cold, sweets or pressure? _____

Do your gums bleed when you brush or floss? _____

Does food or floss catch between your teeth? _____

Do you have dry mouth? _____

Have you had any periodontal (gum) treatments? _____

Have you ever had orthodontic (braces) treatment? _____

Have you had any problems associated with previous dental treatment? _____

Have you ever had nitrous oxide sedation (gas)? _____

Is your home water supply fluoridated? _____

Do you have earaches or neck pain? _____

Do you have any clicking or popping or discomfort in the jaw? _____

Do you brux or grind your teeth? _____

Do you have ulcers or sores in your mouth? _____

Do you wear partials or dentures? _____ _____

Have you ever had a serious injury to your head or mouth? _____

Are you currently experiencing dental pain or discomfort? _____

What is the reason for your dental visit today? _____

If there was something about your smile you could change, what would it be? _____

William E. Wolf, D.D.S.
Kimberly A. Peters, D.M.D.

Medical History

Physician's Name _____ Office Phone _____
Physician's Address _____

Are you in good health? _____

Any change in your general health or have you had any surgeries within the past year? If so, please state.

_____

Are you currently under the care of a physician? _____ If yes, what condition is being treated?

_____

Are you currently taking any prescription medication, over the counter medication, vitamins, herbal or dietary supplements? I so, please list them here. _____

_____

Are you allergic to or made sick by penicillin or other antibiotics; codeine or other narcotics; sulfa drugs; barbiturates, sedatives, or sleeping pills; aspirin; local anesthetics or latex (rubber)? If so, please specify below.

_____

Have you had an orthopedic total joint (hip, knee, elbow, finger) replacement? _____ Date: _____

Have you had any surgical plates, pins, or screws placed? _____ Date: _____

Do you smoke or use smokeless tobacco? _____

Women: Are you pregnant? _____ Obstetrician's Name _____ Due Date: _____

CIRCLE ANY OF THE FOLLOWING WHICH YOU HAVE HAD OR HAVE AT PRESENT

Prolonged bleeding	Emphysema	HIV Positive
Heart Disease/Attack	Cough & Chronic Bronchitis	AIDS
Angina Pectoris	Tuberculosis (TB)	Hepatitis A (infectious)
Mitral Valve Prolapse	Asthma	Hepatitis B (serum)
High Blood Pressure	Hay Fever	Liver Disease
Heart Murmur	Sinus Trouble	Yellow Jaundice
Rheumatic Fever	Allergies or Hives	Blood Transfusion
Congenital Heart Failure	Diabetes	Drug Addiction
Scarlett Fever	Thyroid Disease	Hemophilia
Artificial Heart Valve	Cancer or Tumor	Venereal Disease
Heart Pacemaker	X-Ray or Cobalt Treatment	Cold Sores
Heart Surgery	Chemotherapy	Genital Herpes
Heart Stent	Radiation	Epilepsy or Seizures
Anemia	Arthritis	Fainting or Dizzy Spells
Stroke	Rheumatism	Ulcers
Kidney Disease	Cortisone Medicine	Psychiatric Treatment
Dialysis	Glaucoma	Eating Disorder
Dental Implants	Bruise Easily	Sickle Cell Disease

Do you have a disease, condition or problem not listed? _____

William E. Wolf, D.D.S.
Kimberly A. Peters, D.M.D.

Consent for Treatment

1. I hereby authorize the doctor or designated staff to take x-rays, study models, photographs, and any other diagnostic aids deemed necessary by the doctor to make a thorough diagnosis of the dental needs for _____ .
   (Name of patient)

2. Upon such diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon by me and the doctor and to employ such assistance as required to provide proper care.

3. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risk. I understand that I can ask for a complete recital of any possible complications.

4. **I acknowledge that I have seen and read a copy of the "Notice of Privacy Practices" for William E. Wolf, D.D.S.**

Note:

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form.

Signature of Patient/Legal Guardian:

_____ Date: _____

Please print name:

_____ Relationship to patient: _____