



Welcome! Wolff Family Dentistry is a practice dedicated to helping patients achieve the smiles they have always wanted. We are a general practice dedicated to fighting periodontal disease and giving our patients the best oral care possible. Our two dentists, Dr. Ronald Wolff and Dr. Alan Wolff are always willing to go the extra mile to ensure their patients maintain excellent oral health. Our hygienists work collaboratively with our doctors to maintain our patients’ teeth!

**Patient Information:**

**Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Preferred Name: \_\_\_\_\_\_­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_**

**Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_\_ Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Social Security Number:** \_\_\_\_\_\_\_\_ - \_\_\_\_\_\_ - \_\_\_\_\_\_\_\_\_

**Employer:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Marital Status (*please circle one*):** Minor Single Married Divorced Widowed Separated

**If Minor Please List Guardian/Parents:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Who may we contact in case of emergency:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Whom may we thank for referring you: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Dental Insurance Information**

**Insurance Company:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

***Subscriber* Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *Subscriber* Birthday: \_\_\_\_\_\_\_­­­\_\_\_\_\_\_\_\_\_\_\_\_**

**Subscriber Employer:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Subscriber ID:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Acknowledgement of Notice of Privacy Practices:**

Here at Wolff Family Dentistry we are determined to keep your information private. Below we would like you let us know whom we are allowed to speak with in regards to your accounts and procedures here at our office. This Notice of Privacy Practice is part of a Governmental Requirement. If you would like more information regarding "Protected Health Information" please feel free to ask one of our staff members to provide you with this information. Please fill out the information below and print and sign your name with the date to acknowledge that you have been offered and/ or received a copy of our Notice of Privacy Practices. Thank you.

**1. May we call you to confirm appointments & mail reminder postcards? *Yes No***

**2. Is there anyone you will authorize us to release your information to?**

**Name Relationship to You Phone Number**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Print Your Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Dependents Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Authorization and Release:**

I certify that I have read and understand the information I have provided in this packet to the best of my knowledge. The information has been accurately answered and I understand that providing false information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my dependent during the period of such Dental care to third party payers or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me, unless other arrangements have already been made with the office. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to be responsible for payment of all service rendered on my behalf or dependents.

X\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature of patient (or parent/ guardian if minor) Date

Who is your primary physician? Please list their number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list any other specialized treatments you are receiving: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all medications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all hospitalizations or major operations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you take a Pre-Med? Yes No

If yes, what is the condition that requires a premedication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who was the surgeon and their number? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is the medication? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your preferred pharmacy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please circle any of the following you have/are taking:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Phen-Fen | Redux | Fosamax | Boniva | Actonel |

Are you allergic to any of the following (Please circle)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Acrylic | Aspirin | Clindamycin | Codeine | Latex |
| Local Anesthetics | Metals | Penicillin | Sulfa Drugs |  |

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use Tobacco? Yes No

Do you use CBD products or cannabis? Yes No

Do you use controlled substances? Yes No

|  |  |  |
| --- | --- | --- |
| AIDS/HIV Positive | Gout | Parathyroid Disease |
| Alzheimer’s Disease | Heart Attack | Psychiatric Care |
| Anaphylaxis | Heart Disease | Radiation Treatments |
| Anemia | Heart Failure | Recent Weight Loss |
| Angina | Heart Murmur | Renal Dialysis |
| Arthritis | Heart Pacemaker | Rheumatic Fever |
| Artificial Heart Valve | Heart Trouble | Rheumatism |
| Artificial Joint | Hemophilia | Scarlet Fever |
| Asthma | Hepatitis A | Seizures |
| Blood Disease | Hepatitis B  | Shingles |
| Blood Transfusion | Hepatitis C | Sickle Cell Disease |
| Cancer | Herpes | Sinus Trouble |
| Chemotherapy | High Blood Pressure | Spina Bifida |
| Congenital Heart Disorder | High Cholesterol | Stomach/Intestinal Disease |
| Convulsions | Hypoglycemia | Stroke |
| Diabetes | Irregular Heartbeat | Swelling of Limbs |
| Easily Winded | Kidney Problems | Thyroid Disease |
| Emphysema | Leukemia | Tonsillitis |
| Epilepsy | Liver Disease | Tuberculosis |
| Excessive Bleeding | Low Blood Pressure | Tumors |
| Fainting Spells/Dizziness | Lung Disease | Ulcers |
| Frequent Cough | Mitral Valve Prolapse | Venereal Disease |
| Genital Herpes | Osteoporosis | Yellow Jaundice |
| Glaucoma | Pain in Jaw Joints |  |

Please circle any that apply:

Please list any other Medical Concerns: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_