

Patient Information (confidential)

Fred J. Wolpert DDS

Ryan E. Wolpert DDS

Name _____ Sex: Male Female Today's Date _____

SS# _____ Birthdate _____ Home Phone _____

Address _____ Cell Phone _____

City _____ State _____ ZIP _____

Employer of Patient or Parent/Guardian _____ Work Phone _____

Business Address _____ City _____ State _____ ZIP _____

Spouse or Parent/Guardian's Name _____ Employer _____ Work Phone _____

Check appropriate box: Minor Single Married Separated Divorced Widowed

If student, Name of School/College _____ City _____ State _____ ZIP _____

Emergency Contact(s) _____ Phone(s) _____

Responsible Party

Name of Person Responsible for this Account _____ Relationship to Patient _____

Address _____ Home Phone _____

City _____ State _____ ZIP _____

E-mail _____ Birthdate _____ Cell Phone _____

Employer _____ Work Phone _____ SS# _____

Insurance Information

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Phone _____

Employer Address _____ City _____ State _____ ZIP _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ ZIP _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

Do you have additional Insurance? Yes No If Yes, complete the following

Name of Insured _____ Relationship to Patient _____

Birthdate _____ SS# _____ Date Employed _____

Name of Employer _____ Union or Local # _____ Phone _____

Employer Address _____ City _____ State _____ ZIP _____

Insurance Company _____ Group # _____ Policy/ID # _____

Ins. Co. Address _____ City _____ State _____ ZIP _____

How much is your deductible? _____ How much have you used? _____ Max. Annual Benefit _____

Update Date	*Office Use Only*	Comment	Initial
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Medical History

Fred J. Wolpert DDS

Ryan E. Wolpert DDS

Patient Name _____

Physician _____ Office Phone _____ Date of last exam _____

Please check all appropriate boxes

1. Are you under medical treatment now? Yes No

2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years? Yes No

If yes, please explain _____

3. Are you taking any medications? Yes No

Antibiotics Yes No

Prednisone Yes No

Nitroglycerin Yes No

Antihistamines Yes No

Tranquilizers Yes No

Sulfa drugs Yes No

Cortisone Yes No

Birth control pill Yes No

Insulin Yes No

Hormone therapy Yes No

Digitalis drugs Yes No

Medicine for high blood pressure Yes No

Have you ever taken bone strengthening medicine (FOSAMAX, Boniva, etc.)? Yes No

Anticoagulants blood thinners (Coumadin) Yes No

Other _____ Yes No

If yes to any above, state drug name, dosage and frequency _____

4. Do you use any tobacco products? Yes No

If yes, Cigarettes Yes No

Chewing tobacco Yes No

5. Have you ever had or are currently under radiation or chemotherapy? Yes No

6. Do you have or have you ever had any of the following?

Pacemaker Yes No

Heart murmur Yes No

Diabetes Yes No

Tuberculosis Yes No

Epilepsy Yes No

Cancer Yes No

Rheumatic Fever Yes No

Thyroid Problem Yes No

Venereal disease Yes No

Other _____ Yes No

Stroke Yes No

Lung disease Yes No

Jaundice Yes No

Hepatitis Yes No

Sinus Trouble Yes No

Kidney disease Yes No

Emphysema Yes No

Arthritis Yes No

Asthma Yes No

Heart attack Yes No

Mitral valve prolapse Yes No

Immune system disorders/STDs Yes No

Artificial/Replacement valves Yes No

Hay fever/Allergies Yes No

7. Are you allergic to or have you had any reactions to the following? Yes No

Local anesthetics Yes No

Penicillin Yes No

Other antibiotics Yes No

(ex: amoxicillin)

Aspirin Yes No

Codeine Yes No

Sulfa Drugs Yes No

Iodine Yes No

Latex Rubber Yes No

Any metals Yes No

Other: _____ Yes No

8. Are you subject to? Yes No

Prolonged bleeding Yes No

Fainting spells Yes No

Seizures Yes No

Excessive urination or thirst Yes No

9. Women Yes No

Are you pregnant? Yes No

If yes, expected delivery date: _____

Patient Dental History

Name of previous dentist _____ Date of last exam _____

Previous dentist's location _____ Date of last cleaning _____

Referred by _____

1. Do your gums bleed while brushing or flossing? Yes No

2. Are your teeth sensitive to hot or cold liquids/foods? Yes No

3. Do you have any sores or lumps in or near your mouth? Yes No

4. Have you had any neck or jaw injuries? Yes No

5. Have you ever had any prolonged bleeding following extractions? Yes No

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such dental care to third party payers and/or health care practitioners. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

X _____

Signature of patient (or parent/guardian if minor)

_____ Date