Patient Information (confidential)

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

Ryan E. Wolpert DDS

Patient Name_____

Physician_____ Office Phone_____ Date of last exam_____

Please check all appropriate boxes

	Yes	No
1. Are you under medical treatment now?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐

If yes, please explain_____

_____

3. Are you taking any medications?	Yes	No
Antibiotics	☐	☐
Prednisone	☐	☐
Nitroglycerin	☐	☐
Antihistamines	☐	☐
Tranquilizers	☐	☐
Sulfa drugs	☐	☐
Cortisone	☐	☐
Birth control pill	☐	☐
Insulin	☐	☐
Hormone therapy	☐	☐
Digitalis drugs	☐	☐
Medicine for high blood pressure	☐	☐
Have you **ever** taken bone strengthening medicine (FOSAMAX, Boniva, etc.)?	☐	☐
Anticoagulants blood thinners (Coumadin)	☐	☐

Other_____

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

_____

_____

	Yes	No
4. Do you use any tobacco products?	☐	☐
If yes, Cigarettes	☐	☐
Chewing tobacco	☐	☐
5. Have you ever had or are currently under radiation or chemotherapy?	☐	☐

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

	Yes	No		Yes	No		Yes	No		Yes	No
Pacemaker	☐	☐	Stroke	☐	☐	Kidney disease	☐	☐	Angina	☐	☐
Heart murmur	☐	☐	Lung disease	☐	☐	Emphysema	☐	☐	Ulcers	☐	☐
Diabetes	☐	☐	Jaundice	☐	☐	Arthritis	☐	☐	Anemia	☐	☐
Tuberculosis	☐	☐	Hepatitis	☐	☐	Asthma	☐	☐	Glaucoma	☐	☐
Epilepsy	☐	☐	Sinus Trouble	☐	☐	Heart attack	☐	☐			
Cancer	☐	☐				Mitral valve prolapse				☐	☐
Rheumatic Fever				☐	☐	Immune system disorders/STDs				☐	☐
Thyroid Problem				☐	☐	Artificial/Replacement valves				☐	☐
Venereal disease				☐	☐	Hay fever/Allergies				☐	☐

Other_____

7. Are you allergic to or have you had any reactions to the following?

	Yes	No
Local anesthetics	☐	☐
Penicillin	☐	☐
Other antibiotics (ex: amoxicillin)	☐	☐
Aspirin	☐	☐
Codeine	☐	☐
Sulfa Drugs	☐	☐
Iodine	☐	☐
Latex Rubber	☐	☐
Any metals	☐	☐

Other:_____

_____

8. Are you subject to?	Yes	No
Prolonged bleeding	☐	☐
Fainting spells	☐	☐
Seizures	☐	☐
Excessive urination or thirst	☐	☐

9. Women	Yes	No
Are you pregnant?	☐	☐

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_____

	Yes	No
1. Do your gums bleed while brushing or flossing?	☐	☐
2. Are your teeth sensitive to hot or cold liquids/foods?	☐	☐
3. Do you have any sores or lumps in or near your mouth?	☐	☐
4. Have you had any neck or jaw injuries?	☐	☐
5. Have you ever had any prolonged bleeding following extractions?	☐	☐

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