CONFIDENTIAL PATIENT INFORMATION

Dr. J.C. Wolfe, D.D.S.
300 Hickman Road, Suite 201
Charlottesville, Va. 22911
434-923-0303

Please complete all spaces on this form
Ask your receptionist for assistance, if necessary

Date: ______________

PATIENT INFORMATION

Patient Name ____
Last | First | Middle | Nickname

Date of Birth ______________ Sex ______ M ______ F Marital Status ______________ SSN ______________

Referred by ______________________ E-Mail ______________________

Name of Person Responsible for Account (person must be present) ______________________ DOB ______________

Address: ____
Street | City | State | Zip

Phone(s): home ______________ cell ______________ SSN ______________

If Patient is a Minor – Name of Parent(s): ____
Last | First | Middle

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Last | First | Middle

Employer (Patient or Parent)

Name: ______________________

Company: ______________________

Address: ______________________

Phone: ______________________

Occupation: ______________________

Employer (Spouse or Parent)

Name: ______________________

Company: ______________________

Address: ______________________

Phone: ______________________

Occupation: ______________________

Dental Insurance Information (Patient or Parent)

Insurance Company ______________________

Address: ______________________

ID#: ______________________

Policy # ______________________

Is Insurance ________ Primary ________ Secondary?

Copied Ins. Card? Yes No

Employer (Spouse or Parent)

Insurance Company: ______________________

Address: ______________________

ID# ______________ DOB ______________

Policy # ______________________

Is Insurance ________ Primary ________ Secondary?

Copied Ins. Card? Yes No

Name of nearest relative not living with you ______________________________

Address: ______________________ Phone: ______________

Name of person to notify in case of Emergency ______________________________

Address: ______________________ Phone: ______________

Drug Reactions: ______________________ Allergies: ______________________

This signature authorizes the practice to release dental information for insurance purposes. It also certifies that the information on this registration form is correct and that, if insured, the benefits are assigned directly to this practice.

____ Date: ______________

SIGNATURE OF PERSON RESPONSIBLE FOR ACCOUNT

PATIENT INFORMATION

DENTAL HEALTH

When was your last dental visit? ________________ How often did you see your dentist? ________

Are any teeth bothering you? ____

Do any of the following cause tooth discomfort? Hot ______ Cold ______ Sweets ______ Chewing ______

What do you use to clean your teeth? ________________ How many times per day? ________

Do your gums bleed while cleaning? ________ Do your gums ever feel tender or swollen? ________

Do you clench or grind your teeth? ____

Do your jaws ever feel tired or ache? ________________ Click or pop? ________________

Do you use tobacco products? ________ If so, what do you use? ________ How often? ________

Do you have frequent headaches? ________________ Earaches? ________________

Have you ever had braces? ____

Have you had your “wisdom” teeth removed? ________ Any complications? ________________

If not, have you ever considered replacing them? ________________________________

Do you have any food traps? ____

Is there anything you would like to change about your smile? ________________________

Have you ever had an unpleasant dental experience? ________________________

Have you ever considered sedation dentistry?: ________________________

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Signature____