Alan Wolkoff, D.M.D.

93 Wedgewood Drive Waterbury, Connecticut 06705

(203) 753-2274

(PLEASE PRINT)

Patient Information

Date_____

Patient_____

Address_____

_____

City State Zip

Sex: ☐ M ☐ F Age_____ Birthdate_____

☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient SS#_____

Occupation_____

Employer_____

Employer Address_____

Employer Phone_____

Spouse's Name_____

Birthdate_____ SS#_____

Occupation_____

Spouse's Employer_____

Whom may we thank for referring you?_____

Email_____

Dental Insurance

Who is responsible for this account?_____

Relationship to Patient_____

Insurance Co._____

Group #_____

Is patient covered by additional insurance? ☐ Yes ☐ No

Subscriber's Name_____

Birthdate_____ SS#_____

Relationship to Patient_____

Insurance Co._____

Group #_____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with_____ and assign directly to Dr._____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature

_____ _____

Relationship Date

Phone Numbers

Home_____ Work_____ Spouse's Work_____ Cell_____

Would you like to receive texts about appointment info? Yes ⬭ No ⬭

Best time and place to reach you_____

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household.)

Name_____ Relationship_____

Home Phone_____ Work Phone_____

Dental History

Reason for today's visit_____

_____

Former Dentist_____

City/State_____

Date of last dental visit_____

Date of last dental X-rays_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

Bad breath	☐ Yes	☐ No
Bleeding gums	☐ Yes	☐ No
Blisters on lips or mouth	☐ Yes	☐ No
Burning sensation on tongue	☐ Yes	☐ No
Chew on one side of mouth	☐ Yes	☐ No
Cigarette, pipe, or cigar smoking	☐ Yes	☐ No
Clicking or popping jaw	☐ Yes	☐ No
Dry mouth	☐ Yes	☐ No
Fingernail biting	☐ Yes	☐ No
Food collection between the teeth	☐ Yes	☐ No
Foreign objects	☐ Yes	☐ No
Grinding teeth	☐ Yes	☐ No
Gums swollen or tender	☐ Yes	☐ No
Jaw pain or tiredness	☐ Yes	☐ No
Lip or cheek biting	☐ Yes	☐ No
Loose teeth or broken fillings	☐ Yes	☐ No
Mouth breathing	☐ Yes	☐ No
Mouth pain, brushing	☐ Yes	☐ No
Orthodontic treatment	☐ Yes	☐ No
Pain around ear	☐ Yes	☐ No
Periodontal treatment	☐ Yes	☐ No
Sensitivity to cold	☐ Yes	☐ No
Sensitivity to heat	☐ Yes	☐ No
Sensitivity to sweets	☐ Yes	☐ No
Sensitivity when biting	☐ Yes	☐ No
Sores or growths in your mouth	☐ Yes	☐ No

How often do you floss?_____

How often do you brush?_____

Dental Registration and History

– OVER –

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Health History

Physician's Name_____ Date of last visit_____

Place a mark on "Yes" or "No" to indicate if you have had any of the following:

AIDS	☐ Yes ☐ No	Epilepsy	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Fainting or dizziness	☐ Yes ☐ No	Radiation Treatment	☐ Yes ☐ No
Arthritis, Rheumatism	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Respiratory Disease	☐ Yes ☐ No
Artificial Heart Valves	☐ Yes ☐ No	Headaches	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Artificial Joints	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Heart Problems	☐ Yes ☐ No	Shortness of Breath	☐ Yes ☐ No
Back Problems	☐ Yes ☐ No	Hepatitis Type_____	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Bleeding abnormally, with extractions or surgery	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Skin Rash	☐ Yes ☐ No
Blood Disease	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Special Diet	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	HIV Positive	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Chemical Dependency	☐ Yes ☐ No	Jaundice	☐ Yes ☐ No	Swelling of Feet or Ankles	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Jaw Pain	☐ Yes ☐ No	Swollen Neck Glands	☐ Yes ☐ No
Circulatory Problems	☐ Yes ☐ No	Kidney Disease	☐ Yes ☐ No	Thyroid Problems	☐ Yes ☐ No
Congenital Heart Lesions	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Cortisone Treatments	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Cough, persistent or bloody	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tumor or growth on head or neck	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Nervous Problems	☐ Yes ☐ No	Ulcer	☐ Yes ☐ No
Emphysema	☐ Yes ☐ No	Pacemaker	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Do you wear contact lenses?	☐ Yes ☐ No	Women: Are you pregnant? Due date_____	☐ Yes ☐ No	Weight Loss, unexplained	☐ Yes ☐ No
		Are you nursing?	☐ Yes ☐ No		

Medications

List medications you are currently taking:

_____

_____

_____

Pharmacy Name_____

Phone_____

Allergies

☐ Aspirin ☐ Local Anesthetic

☐ Barbiturates (Sleeping pills) ☐ Penicillin

☐ Codeine ☐ Sulfa

☐ Iodine ☐ Other_____

☐ Latex _____

Updates (To be filled in at future appointments)

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?_____

Are you taking any new medications?_____ If so, what_____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____

Has there been any change in your health since your last dental appointment? ☐ Yes ☐ No

For what conditions?_____

Are you taking any new medications?_____ If so, what?_____

Patient's Signature_____ Date_____

Doctor's Signature_____ Date_____