PATIENT HEALTH HISTORY & REGISTRATION
Dr. Charles Wolfe

PATIENT INFORMATION

PATIENT FULL NAME_____ SEX: M F BIRTHDATE_____ AGE_____

SOCIAL SECURITY #_____ IF PATIENT IS A MINOR, PARENT OR GUARDIAN_____

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?_____

RESPONSIBLE PARTY INFORMATION

FULL NAME_____ MARITAL STATUS_____ BIRTHDATE_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE_____ CELL PHONE_____ WORK PHONE_____

EMAIL_____ RELATION TO PATIENT _____

SOCIAL SECURITY #_____ DRIVER'S LICENSE #_____

EMPLOYER:_____ OCCUPATION_____

EMERGENCY CONTACT

FULL NAME_____ RELATIONSHIP_____ PHONE_____

ADDRESS_____

PRIMARY INSURANCE

INSURANCE NAME_____

SUBSCRIBER_____

SUBSCRIBER EMPLOYER_____

ID #_____ GROUP_____

SECONDARY INSURANCE

INSURANCE NAME_____

SUBSCRIBER_____

SUBSCRIBER EMPLOYER_____

ID #_____ GROUP_____

DENTAL HISTORY

HOW LONG SINCE YOU BEEN TO A DENTIST?	IS YOUR DENTAL HEALTH: GOOD FAIR POOR
LAST COMPLETE DENTAL EXAM:	ARE YOU HAPPY WITH THE WAY YOUR SMILE LOOKS?
LAST SET OF FULL MOUTH X-RAYS:	DO YOU REGULARLY FLOSS?
ARE YOU HAVING ANY PROBLEMS NOW?	HAVE YOU HAD ANY (GUM) TREATMENTS?
DO YOU WEAR DENTURES?	ARE YOU AWARE OF GRINDING OR CLENCHING?

NAME OF PREVIOUS DENTIST_____ CITY_____ STATE_____

MEDICAL HISTORY

DO YOU HAVE ANY CURRENT HEALTH PROBLEMS?_____

ARE YOU UNDER PHYSICIAN'S CARE NOW?_____

WHAT ARE YOUR CURRENT MEDICATIONS IF ANY?_____

ARE YOU PREGNANT?_____ DO YOU USE ANY FORM OF TOBACCO?_____ TAKEN FEN-PHEN/ REDUX?_____

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MEDICAL HISTORY

PLEASE CHECK THE FOLLOWING WHICH YOU HAVE HAD, OR PRESENTLY HAVE.

AIDS/HIV POS.	EPILEPSY	RADIATION TREATMENT
ANAPHYLAXIS	FAINTING	RESPIRATORY TREATMENT
ANEMIA	GLAUCOMA	RHEUMATIC/SCARLET FEVER
ARTHRITIS	HEADACHES	SHINGLES
ARTIFICIAL HEART VALVES	HEART MURMUR	SHORTNESS OF BREATH
ARTIFICIAL JOINTS	HEART PROBLEMS	SKIN RASH
ASTHMA	HEMOPHILIA	SPINA BIFIDA
ATOPIC	HERPES	STROKE
BACK PROBLEM	HEPATITIS	SURGICAL IMPLANT
BLOOD DISEASE	HIGH BLOOD PRESSURE	SWELLING OF FEET
CANCER	JAW PAIN	THYROID DISEASE
CHEMICAL DEPENDENCY	KIDNEY DISEASE	TOBACCO HABIT
CHEMOTHERAPY	MATERIAL ALLERGIES	TONSILIITIS
CIRCULATORY PROBLEMS	MITRAL VALVE PROBLEMS	TUBERCULOSIS
CORTISONE TREATMENTS	ANXIETY	ULCER/ COLITIS
COUGH	PACEMAKE/HEART SURGERY	VENEREAL DISEASE
COUGH UP BLOOD	PSYCHATRIC CARE	**USE OF CPAP**
DIABETES	RAPID WEIGH CHANGE	**SLEEP APNEA**

ALLERGIES

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

ASPRIN LOCAL ANESTHETIC ERYTHROMYCIN LATEX NITROUS OXIDE

CODEINE PENICILLIN

ALLERGIES TO ANY OTHER MEDICATION OS SUBSTANCE? (PLEASE LIST)

_____

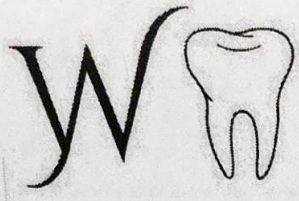
ANY OTHER MEDICAL INFORMATION YOU FEEL DR. CHARLES WOLFE SHOULD KNOW ABOUT?

_____

FAMILY PHYSICIAN_____ PHONE_____

PATIENT SIGNATURE_____ DATE_____

DENTIST SIGNATURE_____DATE_____



610-691-6522

www.Facebook.com/WolfeDental
www.TheBethlehemDDS.com

Please read this entire page and initial each line, sign and date at the bottom

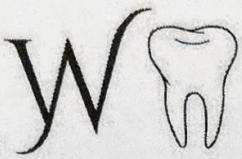
At Wolfe Dental, we believe that you deserve the best care. We always present you with the ideal treatment plan and it is your decision to do all of it, some of it, or none of it, we truly understand and believe in a patient driven and patient first care. Each year, we provide outstanding care to thousands of people from ages 0-100! We are so happy you have decided to join us and we hope you refer your friends and family as well. Here are some policies about us:

_____ **INSURANCE** Your dental benefits are based upon a contract between you, your employer, and your insurance company. We are merely a third party to your insurance. We provide information to you based on in information your insurance has provided us and we give **ESTIMATES ONLY** on your treatment plan and bill at time of service based on this information. Final bills are determined once services are rendered and insurance has paid. Please call your insurance if you have any questions about your plan.

_____ **BALANCES:** Payment is due at the time of service. If you are unable to pay at the time of service please let us know with more than a 2 business day notice so we may reschedule you at a time in which you are able to make payment. If your insurance does NOT PAY within 30 days you will begin to be billed as you are ultimately responsible for all charges incurred at our office. Please note that some services are sent to a lab to be CUSTOM MADE JUST FOR YOU (crowns, bridges, partials, dentures, nightguards, invisalign, and retainers) these are non refundable and are not able to be "returned".

_____ **BROKEN APPOINTMENTS:** If you fail to appropriately cancel with a two business day notice or, do not show more than twice, you will be required to pay a missed appointment charge of $50 before scheduling another appointment. We do understand that sometimes emergencies happen- and please let us know if they do. As a courtesy to you, we send reminders via email, text message, and courtesy calls to remind you of your appointment and we do ask that you give us the same courtesy of a call if you cannot make your appointment as well. We have a limited number of rooms and they are prepared especially for each person, and when you do not show our staff have to take extra time to redo the entire room for someone else. Thank you for your understanding in this matter.

Sign:_____ Date: _____



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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT—PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Jackie
Telephone: 610-691-6522 Fax: 610-691-3040
E-mail: WolfeDentalPa@gmail.com
Address: 5250 Freemansburg Ave. Easton, Pa 18045

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.
Include completed Consent in the patient's chart.

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Please Email Digital X-rays to: WolfeDentalPA@Gmail.com

Date:_____

Record Transfer for:_____

Date of Birth:_____

Previous Dentist:_____

_____

_____Phone:_____

Please send a copy of the most recent radiographs to our office.

Date of last Hygiene visit:_____

Thank you in advance for the timely response to this letter.

I authorize the release of my records from the above.

Patient or Guardian Signature:_____