Patient Information

White Wolf Dental | 1221 Dunlawton Avenue, Port Orange, FL 32127 | (386) 304-1181

Confidential

Welcome to our office. To help us meet your healthcare needs, please complete this form. Ask us if you need assistance.

Patient Information

Full name

Date

Social Security #

Birthdate

Home phone

Cell phone

Street address

City

State

ZIP

Email

Driver's license #

Preferred appointment confirmation method: ☐ Phone ☐ Email ☐ Text Message

Patient's or parent's employer

Work phone

Business address

City / State / ZIP

Spouse or parent's name

Employer

Work phone

How Did You Hear About Our Office?

☐ TV ☐ Google ☐ Website ☐ Yellow Pages ☐ Drive By ☐ Brochure

Friend

Patient

Emergency contact

Phone

Responsible Party & Insurance Information

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Responsible Party

Name of person responsible for account

Relationship to patient

Contact number

Birthdate

Employer

Work phone

Social Security #

Is this person currently a patient in our office? ◯ Yes ◯ No

Preferred payment method: ☐ Cash ☐ Personal Check ☐ Visa/Mastercard ☐ Discover ☐ Care Credit

Insurance Information

Name of insured

Relationship to patient

Birthdate

Social Security #

Date employed

Work phone

Employer

Union or local #

Insurance company

Group #

Policy / ID #

Please complete all applicable fields. Ask our team if you need assistance.

Patient Medical History

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Physician _____ Office phone _____ Last exam _____

1. Are you under medical treatment now? ◯ Yes ◯ No

2. Hospitalized for surgery or serious illness within the last 5 years? ◯ Yes ◯ No

3. Taking any medications, including non-prescription medicine? ◯ Yes ◯ No

4. Currently taking or ever taken osteoporosis medications? ◯ Yes ◯ No

5. Do you use tobacco? ◯ Yes ◯ No

6. Do you use controlled substances or recreational drugs? ◯ Yes ◯ No

If yes, explain hospitalization / medications / osteoporosis details:

Allergies

- ☐ Local anesthetics (e.g. novocaine)
- ☐ Penicillin
- ☐ Other antibiotics
- ☐ Sulfa drugs
- ☐ Sedatives
- ☐ Iodine
- ☐ Aspirin
- ☐ Ibuprofen
- ☐ Tylenol
- ☐ Codeine
- ☐ Metals (e.g. nickel, mercury)
- ☐ Latex rubber
- ☐ Other

Other allergy details _____

Additional Health Questions

Pregnant or think you may be pregnant? ◯ Yes ◯ No

Nursing? ◯ Yes ◯ No

Taking oral contraceptives? ◯ Yes ◯ No

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Conditions - check all that apply

- [ ] High Blood Pressure
- [ ] Heart Attack
- [ ] Rheumatic Fever
- [ ] Swollen Ankles
- [ ] Fainting
- [ ] Seizures
- [ ] Low Blood Pressure
- [ ] Epilepsy / Convulsions
- [ ] Cancer
- [ ] Radiation Therapy
- [ ] Diabetes
- [ ] Kidney Diseases
- [ ] AIDS or HIV Infection
- [ ] Thyroid Problem
- [ ] Sight Impaired
- [ ] Hearing Impaired
- [ ] Heart Disease
- [ ] Mitral Valve Prolapse
- [ ] Congestive Heart Failure
- [ ] Cardiac Pacemaker
- [ ] Heart Murmur
- [ ] Angina
- [ ] Frequently Tired
- [ ] Anemia
- [ ] Emphysema / COPD
- [ ] Tuberculosis
- [ ] Asthma
- [ ] Arthritis
- [ ] Joint Replacement or Implant
- [ ] Hepatitis / Jaundice
- [ ] Sexually Transmitted Disease
- [ ] Stomach Troubles / Ulcers
- [ ] Vertigo
- [ ] Neck Pain
- [ ] Back Pain
- [ ] Chest Pains
- [ ] Easily Winded
- [ ] Stroke
- [ ] Hay Fever / Allergies
- [ ] Glaucoma
- [ ] Recent Weight Loss
- [ ] Liver Disease
- [ ] Other

Other condition details

Patient Dental History & Authorization

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Previous dentist / location

Last exam / cleaning

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. Are your teeth sensitive to sweet or sour liquids/foods? ◯ Yes ◯ No

4. Do you feel pain in any of your teeth? ◯ Yes ◯ No

5. Do you have sores or lumps in or near your mouth? ◯ Yes ◯ No

6. Have you had any head, neck, or jaw injuries? ◯ Yes ◯ No

8. Do you have frequent headaches? ◯ Yes ◯ No

9. Do you clench or grind your teeth? ◯ Yes ◯ No

10. Do you bite your lips or cheeks frequently? ◯ Yes ◯ No

11. Have you had difficult extractions in the past? ◯ Yes ◯ No

12. Prolonged bleeding following extractions? ◯ Yes ◯ No

13. Have you had orthodontic treatment? ◯ Yes ◯ No

14. Do you wear dentures or partials? ◯ Yes ◯ No

15. Received oral hygiene instructions for teeth and gums? ◯ Yes ◯ No

16. Do you like your smile? ◯ Yes ◯ No

7. Jaw problems experienced (check all that apply):

☐ Clicking ☐ Pain (joint, ear, side of face) ☐ Difficulty opening or closing ☐ Difficulty chewing

If dentures/partials, date of placement

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 understand that providing incorrect information can be dangerous to my health. 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 payors and/or health practitioners. I agree to be responsible for payment of all service rendered on my behalf or my dependents.

Signature of patient (parent or minor)

Date

Doctor's signature

Date