Keep the smile you deserve.

Welcome! Wolff Family Dentistry is a practice dedicated to helping patients achieve the smiles they have always wanted. We are a general practice dedicated to fighting periodontal disease and giving our patients the best oral care possible. Our two dentists, Dr. Ronald Wolff and Dr. Alan Wolff, are always willing to go the extra step to ensure their patients maintain excellent oral health. Our hygienists work collaboratively with our doctors to maintain our patients' teeth!

Patient Information:

Legal Name: ______________________________ Preferred Name: _________________

Birthday: _____________________ Social Security Number: ________________________

Home Phone:________________________ Cell Phone: __________________________

Address: ____

City: _________________________ State: ____________ Zip:_____________

Email: ____

Employer: __________________________ Work Phone: __________________________

Preferred Pharmacy: _____________________ Pharmacy Zip: _____________________

Are you (please circle one): Minor Single Married Divorced Widowed Separated

If Minor Please List Guardian/Parents: ____

Whom may we thank for referring you: ______________________________________

Dental Insurance Information

Subscriber Name:__________________________ *Subscriber* Birthday:_________________

Subscriber Employer:_______________________ Subscriber ID:_____________________

Insurance Company:_______________________

Wolff Family Dentistry, LLP

Acknowledgement of Notice of Privacy Practices, and Authorization and Release:

Here at Wolff Family Dentistry we are determined to keep your information private. Below we would like you let us know whom we are allowed to speak with in regards to your accounts and procedures here at our office. This Notice of Privacy Practice is part of a Governmental Requirement. If you would like more information regarding "Protected Health Information" please feel free to ask one of our staff members to provide you with this information.

Please fill out the information below and print and sign your name with the date to acknowledge that you have been offered and/ or received a copy of our Notice of Privacy Practices. Thank you.

1. May we call you to confirm appointments & mail reminder postcards? Yes No

2. Is there anyone you will authorize us to release your information to?

Name	Relationship to You	Phone Number

Who may we contact in case of emergency: ____

Phone Number: ___________________________

I certify that I have read and understand the information I have provided in this packet to the best of my knowledge. The information has been accurately answered and I understand that providing false 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 dependent during the period of such Dental care to third party payers or health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me, unless other arrangements have already been made with the office. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to be responsible for payment of all service rendered on my behalf or dependents.

_________________________________ _________________________________

Signer's Printed Name Dependent's Printed Name if Signing for a Minor

_________________________________ _________________________________

Signature Date