

NEW PATIENT PROFILE

Patient Account Number _____ Date _____

Last Name _____ First Name _____ Middle Name _____ Preferred Name _____

Date of Birth ___/___/___ Age ___ Male Female Occupation _____

Soc. Sec. # _____ - _____ - _____ Marital Status _____

Home Address _____ E-Mail _____

City/State/Zip _____ Home Tel.: _____

Business Tel.: _____ Cell Phone Tel.: _____

REFERRAL PROFILE

Whom may we thank for referring you to our practice? _____

Family/Friend Magazine/Newspaper Other Doctor/Dentist Facebook Google/Website Television Word of Mouth

PARENTAL PROFILE FOR PATIENTS UNDER 21

Father's Name _____ Marital Status _____

Home Address _____

Date of Birth ___/___/___ Soc. Sec. # _____ - _____ - _____ City _____ State _____ Zip _____

Home Tel.: _____ Cell Phone: _____ Business Tel.: _____

Employer _____ Occupation _____

Mother's Name _____ Marital Status _____

Home Address _____

Date of Birth ___/___/___ Soc. Sec. # _____ - _____ - _____ City _____ State _____ Zip _____

Home Tel.: _____ Cell Phone: _____ Business Tel.: _____

Employer _____ Occupation _____

DENTAL INSURANCE INFORMATION

Please give the receptionist your dental insurance card to make a photo copy.

Insured 1: Name _____ Insured's Soc. Sec. # _____ - _____ - _____

Insured's Employer _____ Insured's Date of Birth ___/___/___

Insurance Company _____ Group # _____ Coverage: Family Individual

Do you have dual coverage? Y N **If yes, please fill below:**

Insured 2: Name _____ Insured's Soc. Sec. # _____ - _____ - _____

Insured's Employer _____ Insured's Date of Birth ___/___/___

Insurance Company _____ Group # _____ Coverage: Family Individual

EMERGENCY INFORMATION

Whom may we contact _____ Relationship _____

Home Address _____

City _____ State _____ Zip _____

MEDICAL HISTORY PROFILE

In order for us to treat you properly, please answer any medical conditions listed below that apply to you. Please note that this information is confidential and will not be released without your permission.

Are you being treated for any medical condition or disorder? Y N

If yes, please list your Physician's name and explain condition: _____

Have you had any serious illness, operation or been hospitalized in the past 5 years? Y N

If yes, please explain: _____

Are you pregnant? Y N If yes, how far are you into your pregnancy? _____

What medications are you taking? _____

Do you have, or have you had any of the following medical conditions/allergies:

Y	N	<u>Conditions</u>	Y	N	<u>Conditions</u>	Y	N	<u>Allergies</u>
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Artificial Heart Valve	<input type="checkbox"/>	<input type="checkbox"/>	Cephalexin
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Cancer-Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Codeine
<input type="checkbox"/>	<input type="checkbox"/>	Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Dental Anesthetics
<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	Erythromycin
<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Metals
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Latex
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Nitrous (laughing gas)
<input type="checkbox"/>	<input type="checkbox"/>	Hip or Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Mitral Valve Prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Penicillin
<input type="checkbox"/>	<input type="checkbox"/>	Pace Maker	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	Specific Foods
<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Shingles	<input type="checkbox"/>	<input type="checkbox"/>	Tetracycline
<input type="checkbox"/>	<input type="checkbox"/>	Sleep Apnea	<input type="checkbox"/>	<input type="checkbox"/>	Stroke			
<input type="checkbox"/>	<input type="checkbox"/>	Jaw Pain (TMJ)	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems			
<input type="checkbox"/>	<input type="checkbox"/>	Tobacco Use	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis			

If you have answered yes to any of the following conditions or allergies or if you have one that is not listed above, please list and explain in the space provided:

COSMETIC PROFILE

Please answer the following questions so that we may get to know you better.

Is it important that you keep your teeth for a lifetime? Y N
Are you happy with the appearance of your teeth? Y N
Are you here for a specific reason? Y N
Please Explain: _____

How many times a day do you brush: _____ Floss: _____

When was your last dental visit and what was it for? _____

I think my present state of dental health is: Poor Fair Good Excellent

Please check off the things that would keep you from pursuing your dental treatment:

Cost Fear Lack of Time Lack of Importance All

Do you have any questions concerning dentistry and oral health that you would like to learn more about?

Do you experience any of the following:

	Y	N
Current Discomfort	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding or Sore Gums	<input type="checkbox"/>	<input type="checkbox"/>
Bad Breath	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Mouth Sores	<input type="checkbox"/>	<input type="checkbox"/>
Swelling or Lumps	<input type="checkbox"/>	<input type="checkbox"/>
Loose Teeth	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to Sweets	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to Heat	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty Opening/Closing	<input type="checkbox"/>	<input type="checkbox"/>
Clicking/Popping Jaw	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>
Clenching/Grinding	<input type="checkbox"/>	<input type="checkbox"/>
Change of Bite	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to Cold	<input type="checkbox"/>	<input type="checkbox"/>
Sensitive to Pressure	<input type="checkbox"/>	<input type="checkbox"/>