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 ____

City State Zip

Date of Birth ____/____/____ Soc. Sec. # _______-_______-________

Home Tel.: ____________________________ Cell Phone: ___________________________ Business Tel.: _____________________________________

Employer ________________________________ Occupation ________________________

Mother's Name ____ Marital Status __________________

Home Address ____

City State Zip

Date of Birth ____/____/____ Soc. Sec. # _______-_______-________

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

Home Tel.: ____________________________ Cell Phone: ___________________________ Business Tel.: ____________________________

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

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

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 experience any of the following:

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

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

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