New Patient Profile

Last Name _____ First Name _____ Nickname_____

Home Address_____ City/State/Zip:_____

Home # _____ Cell # _____ Work # _____

E-Mail_____ Date of Birth _____Male _____ Female___

Social Security # _____Single____ Married____ Other___ Spouse's name_____

Occupation_____ Employer's Name_____

Closest Relative not living with you: Name/Phone #_____

Appointment/Referral Profile

Email confirmations to: _____

and/or send a text message to: _____

I understand that my appointment is a specific reserved time for me. Each 1-hour appointment must be cancelled with a minimum of 24 business hours notice or regrettably there will be a charge of $50 per hour for all missed/cancelled appointments. Please initial _____

Who may we thank for referring you to our practice?

Family member or friend _____ Other patient or doctor_____

Magazine, journal article, or TV show _____ Other _____

Aesthetic Profile

Please answer the following questions so we can get to know you better:

Are you happy with the appearance of your teeth?	☐ Yes	☐ No
Would you like your teeth to look whiter?	☐ Yes	☐ No
Would you like to see your smile look different?	☐ Yes	☐ No
Do you like the shape of your teeth?	☐ Yes	☐ No
Do you have discolored teeth that bother you?	☐ Yes	☐ No
Are you here for a specific reason?	☐ Yes	☐ No

Please explain_____

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

☐ Cost ☐ Fear ☐ Lack of time ☐ Lack of importance ☐All

I understand and authorize Dr. Jeffrey Weller and his associates to take all diagnostic materials necessary to make a final diagnosis of dental treatment. Diagnostic materials may include intra-oral pictures, radiographs, diagnostic models, photographs and slides. This material may be used for lectures, articles, and or publication. I authorize Dr. Jeffrey Weller and associates to perform and /or administer any and all forms of treatment, medication, and anesthesia that may be necessary. I fully understand that using general anesthetics agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications. I understand that the dental treatment presented to me is my financial responsibility and that all fees for services are due and payable upfront, prior to the start of my services to be rendered. I have received a copy of the Office's Notice of Privacy Practices; I consent to the use and disclosure of my protected health information to carry out treatment, payment activities, and health care operations.

Signature_____ Date_____

Medical History Profile

In order for us to treat you properly, please check off any medical conditions listed below that apply to you.

Are you being treated for any medical condition or disorder? ☐ Yes ☐ No
If yes, please explain: _____

Are you pregnant? □ Yes □ No

What medications are you taking? _____

Are you allergic to any medication? _____

Are you allergic to any antibiotics? _____

Are you allergic to local anesthesia, nitrous oxide, or any dental material? _____

Do you have, or have you ever had any of the following:

Heart Murmur	Yes	No	Venereal Disease	Yes	No
Heart Disease	Yes	No	Chronic Diarrhea	Yes	No
High Blood Pressure	Yes	No	Steroid Medication	Yes	No
Thyroid Disease	Yes	No	Alcoholism	Yes	No
Diabetes	Yes	No	Cosmetic Surgery	Yes	No
Anemia	Yes	No	Night Sweats	Yes	No
Stroke	Yes	No	Hip Replacement	Yes	No
Drug Addiction	Yes	No	Joint Replacement	Yes	No
Blood Transfusion	Yes	No	Leukemia	Yes	No
Mitral Valve Prolapse	Yes	No	Arthritis	Yes	No
Lupus	Yes	No	Chemotherapy	Yes	No
Hepatitis A	Yes	No	Cancer	Yes	No
Hepatitis B	Yes	No	Tuberculosis	Yes	No
Hepatitis C	Yes	No	Radiation Treatment	Yes	No
TMJ	Yes	No	Stomach Problems	Yes	No
Heart Surgery	Yes	No	Kidney Trouble	Yes	No
Liver Disease	Yes	No	Sinus Trouble	Yes	No
Epilepsy or Seizures	Yes	No	Pain in Joints	Yes	No
Blood Disorders	Yes	No	Lung Disease	Yes	No
Pacemaker	Yes	No	HIV	Yes	No
Coronary Artery Disease	Yes	No	AIDS	Yes	No
Psychiatric Treatment	Yes	No	Latex Allergy	Yes	No

Please list any other medication, allergy, or medical condition not listed above:_____

_____

Please explain any “Yes” answers above: _____

_____

Patient’s Signature_____Date_____

Doctor’s Signature_____Date_____