

# NEW YORK SMILE INSTITUTE

## AESTHETIC & IMPLANT DENTISTRY



### New Patient Profile

Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last
First
MI

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: (Home): [\_\_\_\_\_] (Work): [\_\_\_\_\_] (Cell): [\_\_\_\_\_] \_\_\_\_\_

E-mail address: \_\_\_\_\_ @ \_\_\_\_\_

Sex:  Male  Female Marital Status:  Single  Married  Divorced  Widowed  Other: \_\_\_\_\_

Company Name & Address: \_\_\_\_\_

Occupation: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Age: \_\_\_\_ S.S.# \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Referred By: \_\_\_\_\_

In case of emergency, contact \_\_\_\_\_ Telephone: \_\_\_\_\_

Date of last dental examination: \_\_\_\_\_

Date of last series of complete mouth x-rays: \_\_\_\_\_

Are you in good health?	Yes	No
Has there been any change in your general health within the past five years?	Yes	No
Do your gums bleed when you brush?	Yes	No
Are you happy with your Smile?	Yes	No
Do you smoke cigarettes, cigars, or pipes?	Yes	No
Are your teeth Yellow?	Yes	No
Would you like to change your Smile?	Yes	No
Whiten your teeth?	Yes	No
Do you have any problem eating certain foods?	Yes	No
Do you have sensitivity to hot or cold foods?	Yes	No
Have you ever been Pre-Medicated with antibiotics before any dental treatment ?	Yes	No
Did you ever have orthodontics?	Yes	No
If yes, how many years _____ at what age _____?		

List ALL hospitalizations and serious illnesses, including dates:

_____	_____
_____	_____
_____	_____

Continue →

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

- |   |                          |  |                          |
|---|--------------------------|--|--------------------------|
| Diagnosed with a Heart Murmur/Mitral Valve?             | <input type="checkbox"/> | Rheumatic Fever or Rheumatic Heart Disease?  | <input type="checkbox"/> |
| Heart attack, angina, or other heart disease?           | <input type="checkbox"/> | Prosthetic or Artificial heart valve?        | <input type="checkbox"/> |
| Irregular heartbeat or pacemaker?                       | <input type="checkbox"/> | Shortness of breathes after mild exercise?   | <input type="checkbox"/> |
| High Blood Pressure?                                    | <input type="checkbox"/> | Swollen Ankles                               | <input type="checkbox"/> |
| Asthma, emphysema, or difficulty breathing?             | <input type="checkbox"/> | Recent increase in thirst?                   | <input type="checkbox"/> |
| Stroke, seizures, or convulsions?                       | <input type="checkbox"/> | Stomach ulcers or stomach problems?          | <input type="checkbox"/> |
| Diabetes?   | <input type="checkbox"/> | AIDS, ARC, HIV infection?                    | <input type="checkbox"/> |
| Recent increase in urination?                           | <input type="checkbox"/> | Arthritis or rheumatism?                     | <input type="checkbox"/> |
| Thyroid Problems?                                       | <input type="checkbox"/> | Prosthetic or Artificial joint?              | <input type="checkbox"/> |
| Kidney trouble or Renal Dialysis?                       | <input type="checkbox"/> | Cancer, radiation treatment, or chemotherapy | <input type="checkbox"/> |
| Hepatitis, liver disease, or jaundice?                  | <input type="checkbox"/> | Venereal disease? Syphilis? Gonorrhea?       | <input type="checkbox"/> |
| Tuberculosis?   | <input type="checkbox"/> | Persistent cough or coughing up blood?       | <input type="checkbox"/> |
| Psychiatric treatment?                                  | <input type="checkbox"/> | Enlarged lymph nodes or swollen glands?      | <input type="checkbox"/> |
| Autoimmune disease or lupus erythematosus?              | <input type="checkbox"/> | Hearing problem or vision problems?          | <input type="checkbox"/> |
| Blood disorder, bleeding tendency or frequent bruising? | <input type="checkbox"/> |  |                          |

Do you have any allergies? Yes      No

If yes, what? \_\_\_\_\_

Have you ever taken penicillin? Yes      No

Have you ever had a bad reaction to any drug or medication? Yes      No

- If yes, what?     Penicillin or other antibiotic     Aspirin  
 Dental anesthetic     Codeine or other narcotics  
 Other \_\_\_\_\_

[WOMEN ONLY]      Are you pregnant? Yes      No

**List all of the drugs or medications you are taking now.**

<u>Name of Medication</u>	<u>Dosage</u>	<u>How Long</u>	<u>Reason</u>
_____	_____	_____	_____
_____	_____	_____	_____

Are you under the care of a physician?  Yes     No

Please provide the MD's name, address and phone number:

\_\_\_\_\_

**Continue →**

**In addition to those you have listed, have you taken any of the following medications or drugs within the past year? If yes please check the appropriate box.**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Medication for asthma                                    | <input type="checkbox"/> Anticoagulants (blood thinners)    | <input type="checkbox"/> Cortisone/other steroids           |
| <input type="checkbox"/> Medication for anxiety (nerves)                          | <input type="checkbox"/> Medication for stomach ulcers      | <input type="checkbox"/> Medication for high blood pressure |
| <input type="checkbox"/> Medication for depression or a disorder                  | <input type="checkbox"/> Cancer, Chemotherapy               | <input type="checkbox"/> Insulin or pills for diabetes      |
| <input type="checkbox"/> Medication for a heart problem                           | <input type="checkbox"/> Aspirin, arthritis/pain medication | <input type="checkbox"/> AZT/other drugs for HIV infection  |
| <input type="checkbox"/> Nitroglycerin or any medication for angina or chest pain | <input type="checkbox"/> Methadone maintenance              | <input type="checkbox"/> Other: _____                       |

*I understand and authorize The New York Smile Institute to take all diagnostic materials needed to make a final diagnosis of dental treatment. Diagnostic materials may include Intra-oral pictures, radiographs, digital radiographs, diagnostic models, photographs and slides. This material may be used for lectures, articles and or publications.*

*I authorize The New York Smile Institute to perform and or administer any and all forms of treatment, medication and anesthesia that may be necessary. I understand that the dental treatment presented to me is my financial responsibility and that all fees for services are due and payable up front and/or at the completion of treatment as authorized by The New York Smile Institute and or administrator.*

*I will assume responsibility of notifying The New York Smile Institute of any changes in my medical history or contact information.*

*I understand that The New York Smile Institute reserve the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.*

*I hereby acknowledge that I have been provided with a copy of the Notice of Privacy Practices.*

*We reserve the right to charge our patients a fee for appointments that are broken or not cancelled with 24 hour notice.*

**Patient's Signature:** \_\_\_\_\_

**Date:** \_\_\_\_\_