Classi Smiles
EXCELLENCE IN COSMETIC & IMPLANT DENTISTRY

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NEW PATIENT PROFILE

DATE _____

NAME _____ (LAST) _____ (FIRST) _____ (MIDDLE)

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE _____ (HOME) _____ (WORK) _____ (CELL)

DATE OF BIRTH _____ AGE _____ S.S.# _____

EMAIL _____

SEX ☐ MALE ☐ FEMALE MARITAL STATUS ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

COMPANY NAME & ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

OCCUPATION _____

REFERRED BY _____

EMERGENCY CONTACT NAME _____ (LAST) _____ (FIRST)

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?Do	☐ YES	☐ NO
your gums bleed when you brush?	☐ YES	☐ NO
Do you smoke cigarettes. cigars, or pipes?	☐ YES	☐ NO
Are you happy with your smile?	☐ 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_____	☐ YES	☐ NO

LIST ALL HOSPITALIZATIONS AND SERIOUS ILLNESSES, INCLUDING DATES

HOSPITALIZATION/ILLNESS	DATE

DO YOU HAVE OR EVER HAD ANY OF THE FOLLOWING:

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

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 **CURRENTLY** TAKING:

Name of Medication	Dosage	How Long	Reason

ARE YOU UNDER THE CARE OF A PHYSICIAN? ☐ YES ☐ NO

PLEASE PROVIDE THE MD'S NAME, ADDRESS, AND PHONE NUMBER:

NAME	ADDRESS	TELEPHONE

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

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

I UNDERSTAND AND AUTHORIZE CLASSI SMILES TO TAKE ALL DIAGNOSTIC MATERIALS NEEDED TO MAKE A FINAL DIAGNOSIS OF DENTAL TREATMENT. DIAGNOSTIC MATERIALS MAY INCLUDE INTRA-ORAL SCANS, RADIOGRAPHS, AND PHOTOGRAPHS. THIS MATERIAL MAY BE USED FOR LECTURES, ARTICLES, AND/OR PUBLICATIONS WITH YOUR CONSENT.

I AUTHORIZE CLASSI SMILES 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 CLASSI SMILES AND/OR ADMINISTRATOR.

I WILL ASSUME RESPONSIBILITY OF NOTIFYING CLASSI SMILES OF ANY CHANGES IN MY MEDICAL HISTORY OR CONTACT INFORMATION.

I UNDERSTAND THAT CLASSI SMILES RESERVES 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 _____