Aesthetic Dental Center

NEW PATIENT PROFILE

Patient's Name _____ Preferred Name _____

Birthdate _____ Age _____ □ Male □ Female

1. What is the main reason for your visit today?

   _____

2. Do you have any dental discomfort at this time? YES NO

   If **YES**, which area? _____

3. How did you find out about our clinic?

   _____

4. When was your last dental check-up?

   _____

5. How have your dental experiences been in the past?

   ___ Excellent ___ Okay ___ Frightening/Painful ___ Upsetting

   If **frightening or upsetting**, please explain: _____

   _____

6. Are you happy with the appearance of your smile? YES NO

   If **NO**, why not? _____

7. Would you like your teeth whiter? YES NO

8. Would you like your teeth straighter? YES NO

9. What days and times are most convenient for you?

   _____

OFFICE USE ONLY

NOTES:

Profession/grade in school:

_____

Number of kids/siblings in family:

_____

Recent changes in personal life:

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