SMILES·NY
COSMETIC AND IMPLANT DENTISTRY

220 EAST 63RD STREET
LOBBY F
NEW YORK, NY 10065

Date:_____

Medical Update

Name:_____ Date of Birth: _____

Home Number: _____ Mobile Number: _____

Work Number:_____ Email: _____

Preferred Contact: Home Work Cell Email

Home Address: _____ Apt# _____

City: _____ State:_____ Zip Code:_____

Dental

Are you currently having any tooth or jaw pains?_____ Yes No
Do your gums bleed when you brush or floss? _____ Yes No
Does food get caught between your teeth
or is it difficult to floss any area of your mouth?_____ Yes No
Would you like whiter teeth? _____ Yes No
Would you like straighter teeth?_____ Yes No
Would you like to see what a smile makeover
would look like on you through digital imaging?_____ Yes No

Medical

Are there any changes in your medical history?_____ Yes No
If yes, please note: _____
Are you taking new medications? _____ Yes No
If yes, please note: _____
Do you have medical allergies?_____ Yes No
Have you had a serious illness or operation within the last year? _____ Yes No
If yes, please note: _____
Do you require premedication? _____ Yes No
If yes, please note:_____

Patient Signature: _____ Date: _____