SMILES·NY

COSMETIC AND IMPLANT DENTISTRY

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

Date:________________

New Patient Information

Name: ________________ Date of Birth: ________ SSN: ________

Home Number: ________________ Mobile Number: ________________

Work Number: ________________ Email: ________________

Preferred Contact: Home Work Cell Email Employer: ________________

Home Address: ________________ Apt# ________

City: ________________ State: ________ Zip Code: ________

Name of Insurance ________________ Group# ________ ID# ________

Dental

What is the reason for your visit? ________________

When was your last dental appointment ________________

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

Medical

Are you being treated for any medical condition? ________ 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: ________