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: _____