

SmilesNY
FishmanRothChase
220 East 63rd Street
New York, NY 10065
212-752-6537
www.SmilesNY.com

Welcome! Thank you for choosing us as your dental health professionals. Please fill out the forms completely.

Today's Date: _____

Name: _____

Date of Birth: _____ Marital Status: _____ SS #: _____

Home Number: _____ Cell Number: _____

Work Phone: _____ Your email address: _____

Employer: _____ Occupation: _____

Home Address: _____ Apt# _____

City: _____ State: _____ Zip code: _____

How would you prefer to be contacted: _____

Emergency Contact: (Name/Number): _____

Whom may we thank for referring you to our practice?: _____

Thank you for taking the time to answer the following questions it enables us to give you the best available care.

Your Dental History

Date of last dental visit _____ Date of last 18 film x-rays _____

Date of last hygiene visit _____

Reason for this visit? _____

Are you in pain? _____ If Yes, please describe _____

Have you ever had a problem with local anesthetic? _____ Yes No

Have you ever been diagnosed with gum disease? _____ Yes No

Have you ever had braces? _____ Yes No

Have you ever had TMJ treatment for your jaw? _____ Yes No

Do your gums bleed while brushing, flossing or on their own? _____ Yes No

Do you have any existing dental work? _____ Yes No

Are you happy with your smile? _____ Yes No

If not, are you interested in cosmetic work? _____ Yes No

Are any of your teeth loose? _____ Yes No

Are any of your teeth sensitive to hot or cold? _____ Yes No

Do you have frequent headaches, earaches or neck pain? _____ Yes No

Have you had your wisdom teeth removed? _____ Yes No

Do you have a high level of anxiety towards dental treatment? _____ Yes No

Please tell us any other concerns you have about your dental treatment:

