TRIBECA SMILES
Because a smile goes a long way.

44 LISPENARD STREET
NEW YORK, NY 10013
T: 212.473.4444
F: 212.473.4477

Date: _____

## PATIENT INFORMATION

_____ Social Security #: _____
Last Name First Name Initial

Email: _____ Home Phone: _____ Cell: _____

Address: _____

City: _____ State: _____ Zip Code: _____

☐ M ☐ F Age: _____ Birthdate: _____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Patient Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Whom may we thank for referring you? _____

In case of emergency, who should be notified? _____ Phone: _____

## DENTAL INSURANCE

Person Responsible for Account: _____
Last Name First Name Initial

Relation to Patient: _____ Birthdate: _____ Social Security #: _____

Address (if different from patient's): _____ Phone: _____

City: _____ State: _____ Zip Code: _____

Patient Employed By: _____ Occupation: _____

Business Address: _____ Business Phone: _____

Insurance Company: _____

Contract #: _____ Group #: _____ Subscriber #: _____

Names of other dependants covered under this plan: _____

## DENTAL HISTORY

Reason for Dental Visit: _____

Former Dentist: _____ Phone: _____

Last date of dental care: _____ Last date of dental X-ray: _____

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Patient Name (Continued): _____

## COSMETIC QUESTIONNAIRE

| | | |
|---|---|---|
| Are you happy with your smile? | ☐ Yes | ☐ No |
| Are you happy with the color of your teeth? | ☐ Yes | ☐ No |
| Do you have any chipped teeth? | ☐ Yes | ☐ No |
| Do you have any stained teeth? | ☐ Yes | ☐ No |
| Would your like to improve your smile? | ☐ Yes | ☐ No |
| Would your like to straighten your teeth? | ☐ Yes | ☐ No |
| Would you like to see an improved smile with computer imaging? | ☐ Yes | ☐ No |
| Are you interested in Acupuncture treatment? | ☐ Yes | ☐ No |
| If Yes, would you like for us to verify if Acupuncture is covered by your insurance? | ☐ Yes | ☐ No |

## MEDICAL HISTORY

Physician's Name: _____ Date of last visit: _____

Have you ever had any serious illnesses or operations? ☐ Yes ☐ No If yes, describe: _____

Have you ever had a blood transfusion? ☐ Yes ☐ No If yes, give approximate dates: _____

(Women) Are you pregnant? ☐ Yes ☐ No Nursing? ☐ Yes ☐ No Taking birth control pills? ☐ Yes ☐ No

Check (☒) if you have or have had any of the following:

- ☐ AIDS
- ☐ Anemia
- ☐ Arthritis, Rheumatism
- ☐ Artificial Heart Valves
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Back Problems
- ☐ Blood Disease
- ☐ Cancer
- ☐ Chemical Dependancy
- ☐ Chemotherapy
- ☐ Circulatory Problems
- ☐ Cortisone Treatments
- ☐ Cough, Persistent
- ☐ Cough up blood
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Fainting
- ☐ Glaucoma
- ☐ Headaches
- ☐ Heart Murmur
- ☐ Heart Problems, describe: _____
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV Positive
- ☐ Jaw Pain
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mitral Valve Prolapse
- ☐ Nervous Problems
- ☐ Pacemaker
- ☐ Psychiatric Care
- ☐ Radiation Treatment
- ☐ Respiratory Disease
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Shortness of Breath
- ☐ Skin Rash
- ☐ Stroke
- ☐ Swelling of feet or ankles
- ☐ Thyroid Problems
- ☐ Tobacco Habit
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcer
- ☐ Venereal Disease

## MEDICATIONS

List any medications currently taking:

_____

_____

## ALLERGIES

_____

_____

☐ I authorize my insurance company to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

☐ I authorize the dentist to release all information necessary to secure the payment of benefits.

☐ I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: _____ Date: _____

Payment is due in full at time of treatment unless prior arrangements have been approved.