Allison T. Moses D.D.S., P.C
18 East 50th Street Suite 11A
New York NY 10022

NEW PATIENT FORM

Patient Name:_____
Email:_____
Cell Phone:_____

It is important that I know your dental history. These facts have a direct bearing on your dental health. The information is confidential and will not be released to anyone. Thank you for taking the time to fill out this questionnaire.

How long since you have seen a dentist?_____

Why did you leave your last dental office?_____

When was your last full set of x-rays?_____

Do you like your smile?	Yes	No
Do you want straighter teeth?	Yes	No
Do you want your teeth whiter?	Yes	No
Is there anything you do not like about your teeth?	Yes	No
Do you grind or clench your teeth?	Yes	No
Do you snore?	Yes	No
Do your gums bleed, or feel tender?	Yes	No
Have you worn braces on your teeth?	Yes	No
Do you smoke?	Yes	No

If yes, explain_____