Patient Information

12 Roosevelt Avenue, Port Jefferson Station, NY 11776
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www.portjeffersonsmiles.com

We are pleased to welcome you to Port Jefferson Smiles, a full service dental practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we'll be glad to help you. We look forward to working with you in maintaining your dental health.

PATIENT INFORMATION

Name _____
Address _____
_____
Sex ☐ Male ☐ Female
Birthdate _____
☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated
Patient SS# _____
Occupation _____
Employer _____
Employers Address _____
_____
Spouse's Name _____

EMERGENCY CONTACT AND PHONE NUMBER

Name _____
Phone _____
Relationship _____

PHONE NUMBERS AND E-MAIL

Patient: Home _____
Cell _____
Email _____
Spouse: Home _____
Cell _____
Email _____

DENTAL INSURANCE

Who is responsible for this account? _____
Relationship to patient _____
Birthdate of insured _____
SS# of insured _____
Address if different from patient _____
_____
Employer _____
Business Address _____
_____
Insurance Company _____
Group # _____
Names of other dependents under this plan _____
_____

ADDITIONAL (SECONDARY) DENTAL INSURANCE

Subscriber Name _____
Relationship to patient _____
Birthdate of insured _____
SS# of insured _____
Address if different from patient _____
_____
Employer _____
Business Address _____
_____
Insurance Company _____
Group # _____
Names of other dependents under this plan _____
_____

DENTAL HISTORY

Reasons for today's visit _____
Date of last dental care _____
What was done? _____
Please mark all that apply:

☐ Bad Breath	☐ Sensitivity to cold
☐ Bleeding Gums	☐ Sensitivity to hot
☐ Clicking or popping jaw	☐ Sensitivity to sweets
☐ Food collection between teeth	☐ Sensitivity to biting
☐ Grinding or clenching teeth	☐ Sores or growths in mouth
☐ Loose teeth or broken fillings	☐ Periodontal treatment

How often do you brush? _____ Floss? _____
How do you feel about the appearance of your teeth? _____
_____
Are you happy with your smile? ☐ Yes ☐ No
Explain: _____
Have you ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ☐ Yes ☐ No
Explain: _____
Other information about your dental health or previous treatment
_____

HOW DID YOU HEAR ABOUT PORT JEFFERSON SMILES?

☐ Print Advertising ☐ Website/Internet ☐ Billboard ☐ TV
☐ Radio ☐ Referral ☐ Insurance Co. ☐ Other _____
Whom may we thank for referring you? _____