

# Waterford Dental Associates, P.C.

815 Hartford Road  
Waterford, Connecticut 06385  
(860) 444-0625

Circle: Mr. Mrs. Miss Ms. Dr.

Patient Name \_\_\_\_\_ Date: \_\_\_\_\_  
(Last) (First) (M)

Patients Social Security #: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Drivers License Number: \_\_\_\_\_

Employer: \_\_\_\_\_ Occupation: \_\_\_\_\_

Employers Address: \_\_\_\_\_

Name of person to contact in emergency: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Home Phone: ( ) \_\_\_\_\_ Work Phone: ( ) \_\_\_\_\_

Whom may we thank for referring you to our office: \_\_\_\_\_

Name of person responsible for payment of this account (if different from above)

Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Social Security #: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Birth Date: \_\_\_\_\_

Address if different from above: \_\_\_\_\_

Employer: \_\_\_\_\_

I will usually pay for treatment by: Cash ( ) Check ( ) Credit card ( )

## DENTAL INSURANCE INFORMATION

Insurance company name: \_\_\_\_\_

Employers name: \_\_\_\_\_

Employees name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

Social Security #: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Group #: \_\_\_\_\_

BC / BS Subscriber #: \_\_\_\_\_ Badge #: \_\_\_\_\_

Your signature below authorizes Waterford Dental Associates to bill your insurance company and make benefits payable to WDA. All expected insurance amounts are estimates only. The undersigned hereby promises to pay for all services rendered by WDA. On default of any payment due the undersigned further agrees to pay the costs of collections, including reasonable attorney's fees and court costs. There will be a monthly billing charge of \$2.00 per month for all unpaid balances. Appointments cancelled or broken without 24 hours advance notice are subject to a \$25.00 charge.

Responsible party signature: \_\_\_\_\_

CONTINUED ON REVERSE SIDE

## DENTAL HISTORY

Do you have any present dental complaints? \_\_\_\_\_

When were your last dental x-rays taken? \_\_\_\_\_

Full mouth x-rays? \_\_\_\_\_ Panoramic x-ray? \_\_\_\_\_

When was your last cleaning? \_\_\_\_\_

How do you feel about a healthy mouth? \_\_\_\_\_

How do you feel about the appearance of your teeth? \_\_\_\_\_

If you could change anything about your smile, what would it be? \_\_\_\_\_

How do you feel about visits to the dentist?

Comfortable ( )      Uncomfortable ( )      Very uncomfortable ( )

## PATIENT'S MEDICAL HISTORY

Medical Doctor: \_\_\_\_\_

Are you in good Health? \_\_\_\_\_ If no, please explain \_\_\_\_\_

Do you have an existing illness? \_\_\_\_\_ If yes, please explain \_\_\_\_\_

Have you been hospitalized in the past two years; if so for what condition?  
\_\_\_\_\_

Do you bleed excessively when cut? \_\_\_\_\_

Do you smoke/chew tobacco? \_\_\_\_\_ If yes how much? \_\_\_\_\_

Please list all medications you are currently taking including the dosage: \_\_\_\_\_

Do you need to premedicate with antibiotics prior to dental treatment? \_\_\_\_\_

Do you have now, or have you had any of the following? Please circle

Pacemaker	Stroke	Epilepsy
Valve replacement	Arthritis	Tumor History
Joint replacement	Asthma	Heart disease
Mitral valve prolapse	Hepatitis	Venereal disease
Thyroid disease	Diabetes	Tuberculosis
Radiation treatment	HIV	Liver disease
High blood pressure	Kidney disease	AIDS
Rheumatic fever	Heart murmur	

Allergy to:	Penicillin	Other antibiotics
	Local anesthetics	Latex
	Nuts	Bananas      Other

Are you pregnant

Other pertinent information  
\_\_\_\_\_

I consent to whatever dental procedures and anesthetics are necessary for the treatment of the above named patient. I also agree to assume financial responsibility for all treatment rendered.

Patient Signature \_\_\_\_\_