WILTON DENTAL ASSOCIATES LLC
44 OLD RIDGEFIELD RD SUITE 212 WILTON, CT 06897
(203) 761-0223

The completion of this form is required in order that the doctor may thoroughly diagnose your condition. It will, of course, be kept confidential.

Name ____ Social Security # ______________
Address ____
City ______________________________ ST________ Zip _________________________
Telephone _________________________ Age ________ Birth Date ____________________
Cellular__________________________ Email ____________________________________

Circle One: Single Married Widowed Divorced

Occupation ____
Employer____ How Long _____________
Address ____ Work Phone ____________
Spouse's Name ____
Spouse's Employer____
Address ____ Work Phone _____________
Who is responsible for this account? ____
Name ____
Address ____
Closest living relative or friend: ____
Name ____
Address ____
How did you hear about us?

- Welcome letter
- Post Card
- Referral from friend or family
- Magazine Article
- Other

Name:

Physician(s): Name ____
Address ____
When was your last complete physical/medical exam? _________________________________
Previous Dentist:
Name ____
Address ____

Payment is expected when services are rendered, unless other arrangements are made in advance. MasterCard, Visa, Discover, American Express and Debit Cards are welcome.

Please circle Yes or No for those that apply to you.

Yes No	Anemia	Yes No	Emphysema	Yes No	Kidney Disease	Yes No	Seizures
Yes No	Arthritis	Yes No	Excessive Bleeding	Yes No	Liver Disease	Yes No	Stomach Problems
Yes No	Artificial Heart Valve	Yes No	Fainting	Yes No	Low Blood Pressure	Yes No	Stroke
Yes No	Artificial Joints	Yes No	Glaucoma	Yes No	Mitral Valve Prolapse	Yes No	Thyroid Disease
Yes No	Asthma	Yes No	Heart Conditions	Yes No	Nervousness/Depression	Yes No	Tuberculosis
Yes No	Blood Disease	Yes No	Heart Lesions	Yes No	Pacemaker	Yes No	Ulcers
Yes No	Bruise Easily	Yes No	Heart Murmur	Yes No	Periodontal Disease	Yes No	Venereal Disease
Yes No	Cancer	Yes No	Heart Surgery	Yes No	Radiation (Head/Neck)		**Women Only**
Yes No	Chemotherapy	Yes No	Hepatitis: A B C	Yes No	Respiratory Problems	Yes No	Birth Control
Yes No	Diabetes	Yes No	High Blood Pressure	Yes No	Rheumatic Fever	Yes No	Nursing
Yes No	Dizziness	Yes No	HIV Positive	Yes No	Rheumatism	Yes No	Pregnant
Yes No	Drug Addiction	Yes No	Jaundice	Yes No	Scarlet Fever		

Do you have any of the following drug allergies?

Yes No	Aspirin	Yes No	Latex	Yes No	Percodan	Please list other allergies
Yes No	Codeine	Yes NO	Anesthetic	Yes No	Penicilin	____________
Yes No	Darvon	Yes No	Nitrous Oxide	Yes No	Antibiotics	____________
Yes No	Erythromycin	Yes No	Sulfa	Yes No	Other Allergies	____________

Please check any of the following drugs you have used at any time:

Yes No	Fosamax	Yes No	Didronel	Yes No	Zometa	Yes No	Boniva
Yes No	Aredia	Yes No	Actonel	Yes No	Skelid	Yes No	Bisphosphonates

List ALL medications you currently take. (Prescription & Over the Counter. Attach List if Needed)

____________ ____________ ____________

____________ ____________ ____________

Do you (check all that apply):

Yes No	Snore	Yes No	Wake up with Dry Mouth or Sore throat
Yes No	Have someone tell you that you snore	Yes No	Wake up tired or groggy
Yes No	Not sleep well	Yes No	Have High Blood Pressure
Yes No	Have daytime sleepiness	Yes No	Have someone tell you that you stop breathing while sleeping
Yes No	Have heart burn		
Yes No	Have Sleep Apnea		

I certify the information recorded on this medical and dental form is correct. I understand it is my responsibility to notify Wilton Dental Assoc. of any changes. I understand if I withhold information regarding allergies, medical conditions, medications, or supplements; I agree not to hold Wilton Dental Associates or its employees liable in the event of death or injury.

Signature (Patient / Guardian) ____________ Date ________ Dentist Signature ________

Please circle Yes or No for those that apply to you.

Yes No	Sensitivity to: Hot Cold Sweet	Yes No	Bleeding, Swollen or Irritated gums
Yes No	Chipped / Broken Teeth	Yes No	Dissatisfied With Appearance of My Teeth
Yes No	Crooked or Tipped Teeth	Yes No	Frequent Headaches
Yes No	Loose Teeth	Yes No	Jaw, Joint Pain
Yes No	Missing or Spaces Between Teeth	Yes No	Grinding or Clenching Teeth
Yes No	Catch Food Between Teeth	Yes No	Uncomfortable or Uneven When I Bite My Teeth Together
Yes No	Dry Mouth or Constantly Thirsty	Yes No	Clicking or Popping of Jaw
Yes No	Smoke or Use Chewing Tobacco	Yes No	Difficulty Opening or Chewing

Please circle Yes or No if you have or have had any of the following?

Yes No	Dentures or Partials	Yes No	Veneers
Yes No	Braces or Clear Braces	Yes No	Jaw Surgery
Yes No	Periodontal Disease or Gum Treatments	Yes No	Root Canals
Yes No	Fixed Bridge	Yes No	Sleep Apnea
Yes No	Dental Implants	Yes No	C-PAP Machine or Oral Sleep Appliance
Yes No	Crown	Yes No	Fear or Anxiety About Dental Treatment

If I could change my smile, I would:

Make My Teeth Whiter	Repair Chipped Teeth
Make My Teeth Straighter	Replace Missing Teeth
Close Spaces or Gaps That Bother Me	Replace Old Crowns That Look Dark or Don't Match
Replace Dark Metal Fillings With Tooth Colored Fillings	Have a Smile Makeover
Fix My Teeth So I'm Not Embarrassed When I Smile	Stop My Jaw From Hunting or Clicking

On a scale of 1-10 with 10 being the highest rating:

How important is your dental health to you?	1 2 3 4 5 6 7 8 9 10
Where would you rate your current dental health?	1 2 3 4 5 6 7 8 9 10

Tell me about my options for replacing missing teeth with Dental Implants?	Yes No
Tell me how I can straighten my teeth in 6 months instead of 2 years and if I'm a candidate?	Yes No
Have you ever been sedated for dental treatment?	Yes No
Are you interested in sedation options?	Yes No
Have you ever whitened your teeth?	Yes No

If this is your first time in our office please answer the following:

Date of last cleaning? ____________ Date of last oral cancer screening? ________ Date of last complete x-rays? ________

What is the most important thing to you about your dental visit today: ______________________________

Why did you leave your previous dentist? ______________________________

Is there any other information about your health that should be known?

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Payment for office services is required at the time they are rendered. The patient is responsible for submitting their bill to their own insurance company. All insurance companies differ as to what they will and will not cover. It is the patient's responsibility to check with their insurance company regarding benefits. We will help whenever possible with any information your insurance company might need from this office.

PLEASE READ AND SIGN

The undersigned hereby agrees that if this account must be referred to an attorney or agency for collection, the undersigned shall be responsible for all reasonable costs and expenses resulting form said collection including but not limited to reasonable attorney's fees and service charge a the maximum allowable legal rate from the date the debt is incurred. A copy of this signature for release of information to your insurance company or referring physician is as valid as the original.

Payment is expected when services are rendered, unless other arrangements are made in advance. Master car, Visa, American Express and Discover are welcome.

Please select preferred method of payment:

Cash	Personal Check	Visa
Master Card	American Express	Discover

Signature ________________________ Date __________________