2486 Pruden Boulevard, Suffolk, Virginia 23434 (757) 539-3021
A Division of Atlantic Dental Care, PLC

Thank you for selecting Gwaltney Dentistry! We will strive to provide you with the best possible dental care. To help us meet all your dental healthcare needs, please complete these forms in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Date_______________

Patient Information (CONFIDENTIAL)

Last Name______________________________ First Name______________________ MI ____ Nickname_______________

Gender ☐ Male ☐ Female Birth Date ______/______/_______ Social Security # _______-______-_________

Check Appropriate Box ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Mailing Address____ Street Address(if different)____________________
Street City State Zip

Phone Numbers Home_______________________ Cell________________________ Work ________________________

Best telephone # to reach you? Please circle *Home* *Cell* *Work.* **Can we *Text* &/or *Email* you? Yes or No** ______________

Email Address____________________________________ **Employer** ____

Employer Address____

Whom may we thank for referring you?_____________________ How did you hear about us?_______________________________

Name of Relative NOT living with you________________________Relationship__________Phone Number__________

Spouse Information

Last Name_________________________ First Name__________________ MI _______ Gender ☐ Male ☐ Female

Birth Date_____/_____/_______ Social Security # _______-______-________

Phone Numbers Home___________________ Cell____________________ Work ____________________

Employer____________________________ Employer Address____

INSURANCE INFORMATION

Policy Holder Name: ____Relationship to Patient_______________

Birth Date_____/_____/_______ Social Security # _______-______-________ Gender ☐ Male ☐ Female

Phone Numbers Home___________________ Cell____________________ Work ____________________

Employer_________________________ Insurance Company____________________ Policy #____________________________

Insurance Address____ Phone Number____________________

Patient Dental History

Previous Dentist_________________ Address____________________ Phone Number______________ Date of Last Exam________

	Yes	No
1. Do your gums bleed while brushing or flossing?............	☐	☐
2. Are your teeth sensitive to hot or cold liquids/food?.......	☐	☐
3. Do you feel pain from any of your teeth? If yes, please explain______________________________	☐	☐
4. Do you have any sores or lumps in or near your mouth?	☐	☐
5. Have you had any head, neck or jaw injuries?...............	☐	☐
6. Have you ever experienced any of the following problems in your jaw?		
Clicking…………………………………………………	☐	☐
Pain (joint, ear, side of face……………………………	☐	☐
Difficulty in opening or closing………………………	☐	☐
Difficulty in chewing…………………………………	☐	☐
7. Do you have frequent headaches?................................	☐	☐
8. Do you clench or grind your teeth?................................	☐	☐
9. Do you bite your lips or cheeks frequently?...................	☐	☐

	Yes	No
10. Have you ever had difficult extractions?..............	☐	☐
11. Have you had any orthodontic treatment?............	☐	☐
12. Do you wear dentures or partials?...................... If yes, Date of placement?_______________	☐	☐
13. Do you like your smile?.. If no, explain___________________________	☐	☐
14. Are you happy with the color of your teeth?.......	☐	☐
15. Have you ever had teeth whitening?.................... If yes, which process did you use and when was the last time you had it?_____________	☐	☐
16. Are you happy with the position of your teeth?	☐	☐

NEXT PAGE

Staff Initials___________

Patient Medical History

Physician________________________ Office Phone______________ Date of Last Exam______________

	Yes	No		Yes	No
1. Are you under medical treatment now?.........................	☐	☐	7. Are you allergic to or have you had any reactions to the following?	☐	☐
2. Have you ever been hospitalized for any surgical operation or serious illness within the last 5 years?......	☐	☐	Codeine..	☐	☐
If yes, explain________________			Ibuprofen...		
3. Are you taking any medication(s) including non-prescription medicine?...	☐	☐	Latex Rubber...	☐	☐
If yes, what medication(s) are you taking__________			Local Anesthetics (e.g. Novocain)...................	☐	☐
			Any Metals (e.g. nickel, mercury, etc................	☐	☐
			Penicillin or any other Antibiotics.....................	☐	☐
4. Do you use tobacco products? What? __________	☐	☐	Other (please list)____________	☐	☐
How much?________________			**8. Women Only:**		
5. Do you use controlled substances?...............................	☐	☐	Are you pregnant or think you might be pregnant?	☐	☐
6. Do you have any of the following?			Are you nursing?..	☐	☐

	Yes	No		Yes	No		Yes	No
High Blood Pressure.........	☐	☐	Heart Disease........................	☐	☐	Chest Pain................................	☐	☐
Heart Attack.....................	☐	☐	Cardiac Pacemaker..............	☐	☐	Heart Trouble............................	☐	☐
Rheumatic Fever............	☐	☐	Heart Murmur........................	☐	☐	High Cholesterol......................	☐	☐
Hepatitis / Jaundice..........	☐	☐	Angina.................................	☐	☐	Stroke......................................	☐	☐
Fainting/ Seizures...........	☐	☐	Frequently Tired...................	☐	☐	Hay Fever / Allergies..............	☐	☐
Asthma..........................	☐	☐	Anemia...............................	☐	☐	Tuberculosis...........................	☐	☐
Low Blood Pressure.........	☐	☐	Emphysema / COPD...........	☐	☐	Radiation Therapy..................	☐	☐
Epilepsy / Convulsions.....	☐	☐	Cancer...............................	☐	☐	Glaucoma...............................	☐	☐
Diabetes.........................	☐	☐	Arthritis...............................	☐	☐	Recent Weight Loss.................	☐	☐
Kidney Disease...............	☐	☐	Joint Replacement or Implant...	☐	☐	Liver Disease...........................	☐	☐
AIDS or HIV Infection.........	☐	☐	Sexually Transmitted Disease..	☐	☐	Respiratory Problems..............	☐	☐
Thyroid Problem............	☐	☐	Stomach Troubles / Ulcers......	☐	☐	Other________________		
Do you Snore	☐	☐	C-PAP Machine	☐	☐	Is C-PAP comfortable?..............	☐	☐

Have you ever taken bone density medication? If so, which ones: ______________________

Has a doctor ever recommened you take a PRE-MED (antibiotics) before dental appointments? (if yes, explain ______________

Do you have a history of DRUG ABUSE? If yes, explain: ______________________

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my health. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to me during the period of such dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist otherwise payable to me. ***I understand that my dental insurance carrier may pay less than the actual bill for services.*** *I agree to be responsible for payment of all services on my behalf or my dependents.*

*X*______________________ ______________ ______________

Signature of Patient/Legal Guardian Relationship Date

Doctor/staff comments: