

# GENTLE DENTAL CENTER

1908 Landstown Centre Way, Suite 120 • Virginia Beach, VA 23456 • [757] 689-2940 • [www.gentledentalcenter.com](http://www.gentledentalcenter.com)

## CONFIDENTIAL PATIENT INFORMATION

Date \_\_\_\_\_  
Name \_\_\_\_\_ Nickname \_\_\_\_\_ Birth Date \_\_\_\_\_  
Sex: M F Marital Status: (Please circle one) Single Married Separated Divorced Widowed  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Email \_\_\_\_\_ Phone (home) \_\_\_\_\_ (cell) \_\_\_\_\_ (work) \_\_\_\_\_  
Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
SSN \_\_\_\_\_ Whom may we thank for referring you? \_\_\_\_\_  
In case of emergency, who should be notified? \_\_\_\_\_ Phone: \_\_\_\_\_  
Are any of your family members patients here? Yes No If so, who? \_\_\_\_\_  
Person responsible for payment of account (person's name to appear on billing statement) Self Spouse Parent or Guardian Other  
If you circled "Self," please skip second section and go on to the third section

## PERSON RESPONSIBLE FOR THIS ACCOUNT

Name \_\_\_\_\_ Birth Date \_\_\_\_\_ M F  
Home Address (If different from above) \_\_\_\_\_ Phone \_\_\_\_\_  
Employer \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Business Address \_\_\_\_\_ Phone \_\_\_\_\_

## PATIENT'S SPOUSE (OR PARENT)

Name of Spouse or Parent or Guardian \_\_\_\_\_ M F DOB \_\_\_\_\_  
Employer \_\_\_\_\_ Social Security Number \_\_\_\_\_  
Business Address \_\_\_\_\_ Phone \_\_\_\_\_

## INSURANCE INFORMATION -

Please allow us to copy your Insurance Card and a Photo ID. Your insurance coverage, if any, is an agreement between you and your carrier. As a courtesy we will be happy to file your insurance for you. You are responsible for all fees at the time of service.

**PLEASE CONTINUE WITH BACK OF FORM**

# CONFIDENTIAL

## MEDICAL HISTORY

Name of your physician \_\_\_\_\_ Date of last physical \_\_\_\_\_  
 Physician's address \_\_\_\_\_ Phone \_\_\_\_\_

Are you taking any medication now? Yes No Please list \_\_\_\_\_

Are you pregnant? Yes No Do you take birth control? Yes No

Do you have any of the following?

	Yes	No		Yes	No		Yes	No
AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Condition	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcer	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Psychological Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Joint Replacement	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Any disability	<input type="checkbox"/>	<input type="checkbox"/>

Are you allergic or have had a reaction to:		Yes	No
Local anesthetics		<input type="checkbox"/>	<input type="checkbox"/>
Penicillin or other antibiotics		<input type="checkbox"/>	<input type="checkbox"/>
Sulfa drugs		<input type="checkbox"/>	<input type="checkbox"/>
Barbiturates, sedatives or sleeping pills		<input type="checkbox"/>	<input type="checkbox"/>
Aspirin		<input type="checkbox"/>	<input type="checkbox"/>
Wine or Foods		<input type="checkbox"/>	<input type="checkbox"/>
Codeine or other narcotics		<input type="checkbox"/>	<input type="checkbox"/>
Other _____		<input type="checkbox"/>	<input type="checkbox"/>

Additional information about your health that we should know: \_\_\_\_\_

Were you ever advised by your doctor to have antibiotics before any medical or dental treatment? Yes No

Have you ever had any serious trouble associated with any previous dental treatment? Yes No

If so, please explain: \_\_\_\_\_

## DENTAL HISTORY

- Yes No Bleeding gums? \_\_\_\_\_
- Yes No Bad breath? \_\_\_\_\_
- Yes No Sore areas in your mouth? \_\_\_\_\_
- Yes No Pain in or near your ears? \_\_\_\_\_
- Yes No Sensitivity to heat, cold or sweets? \_\_\_\_\_
- Yes No Frequent headaches or tired jaws? \_\_\_\_\_
- Yes No Were Panoramic (Full mouth x-rays) taken within the last 3 years that we can obtain from your previous dentist? \_\_\_\_\_
- Yes No Are you happy with your smile? If no, why not? \_\_\_\_\_
- Date of last dental visit? \_\_\_\_\_
- Yes No Do you use smokeless tobacco? \_\_\_\_\_
- Yes No Do you smoke? \_\_\_\_\_
- Yes No Have you ever been treated by a Periodontist? (Gum Specialist) \_\_\_\_\_
- Yes No Have you ever been treated by an Orthodontist? (Braces) \_\_\_\_\_
- Yes No Do you have a specific dental problem or pain? \_\_\_\_\_
- Yes No Do you have TMJ? \_\_\_\_\_

## AUTHORIZATION

- I (we) the undersigned authorize treatment by the doctor and supporting staff members.
- I (we) consent to the release of information as may be necessary for insurance, dental, medical consult or collection.
- I (we) understand there may be a minimum charge of \$50.00 for broken appointments without 24 hours notice.
- I (we) understand that my insurance will be files as a courtesy, but I am responsible for full payment of services.
- I (we) accept full responsibility for payment of all charges incurred as well as attorneys fees of 33.3% and any other related costs of collection should actions become necessary.
- There will be a \$10.00 monthly rebilling fee added to any account that is delinquent, plus interest of 18%.
- I (we) certify all the above to be filed out correctly and truthfully.

**PAYMENT OF PERSONAL FEES** Please check method of payment best for you: Cash Check Mastercard / Visa

Patient's Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_