OYSTER POINT DENTISTRY

Zachary Duman D.D.S.
(757)596-6216

Today's Date: _____

Patient Name: _____
Last First Middle

Address: _____

City, State, Zip: _____

Email: _____

Home & Cell Phone: _____

Birth Date: _____

Patient's SSN: _____

Parent or Spouse: _____

Emergency Contact: _____

Referred By: _____

Employer: _____

Name of Insured: _____

Insurer's Birth Date: _____

Insurer's SSN: _____

Insurance Comp: _____

Insurance ID#: _____

PATIENT MEDICAL HISTORY

PHYSICIAN: _____ **OFFICE PHONE:** _____

		Yes	No
1.	Are you under any medical treatment now?	❑	❑
2.	Have you been hospitalized for any surgical operation or serious illness?	❑	❑
3.	Are you taking any medication(s) including non-presctiption medicine? If yes, what medication(s) are you taking? Please list in box provided.	❑	❑
4.	Do you use tobacco?	❑	❑
5.	Do you use alcohol, or other recreational drugs?	❑	❑

6. Are you allergic to or have you had any reactions to the following?

	Yes	No		Yes	No		Yes	No
Local anesthetics (eg. Lidocaines)	❑	❑	Barbiturate	❑	❑	Aspirin	❑	❑
Penicillin or other antibiotics	❑	❑	Sedatives	❑	❑	Latex	❑	❑
Sulfa drugs	❑	❑	Iodine	❑	❑	Other Allergies:		

7. **WOMEN ONLY:**

a) Are you or think you may be pregnant?	❑	❑
b) Are you nursing?	❑	❑
c) Are you taking birth control pills?	❑	❑

8. Do you have or have you had any of the following?

	YES	NO
High or Low Blood Pres.	❑	❑
Blood Thinners (Aspirin, Coumadin, Eliquis)	❑	❑
Biophosphonates (Prolia, Boniva, Fosamax)	❑	❑
Joint Replacement	❑	❑
PreMed Antibiotic for Spinal Fusion/Hip/Joint Replacement	❑	❑
Diabetes	❑	❑
Cancer	❑	❑
Radiation/Chemo	❑	❑
Arthritis/Osteoporosis	❑	❑
Hepatitis/Jaundice	❑	❑

	YES	NO
Angina/Chest Pain	❑	❑
Stroke	❑	❑
STD's	❑	❑
Stomach Troubles	❑	❑
Hay Fever/Allergies	❑	❑
Lupus	❑	❑
Heart Murmur	❑	❑
Heart Attack/Disease	❑	❑
Rheumatic Fever	❑	❑
Fainting	❑	❑
Seizures	❑	❑
Asthma	❑	❑
Epilepsy or Convulsion	❑	❑
Leukemia	❑	❑

	YES	NO
Kidney Disease	❑	❑
AIDS/ HIV Infection	❑	❑
Thyroid problem	❑	❑
Cardiac Pacemaker	❑	❑
Liver Disease	❑	❑
Respiratory Problems	❑	❑
Tuberculosis	❑	❑
Anxiety	❑	❑
Cholesterol	❑	❑
Sleep Apnea	❑	❑

BIOLOGICS:	YES
Humira	❑
Remicade	❑
Enbrel	❑
Rituxan	❑
Avastin	❑
Herceptin	❑

IF YES, Additional Information:

_____

_____

_____

Medicines, Vitamins & Supplements:

_____

_____

_____

_____

_____

_____

_____

_____

Please Read: 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 also hereby authorize payment to Oyster Point Dentistry of the group insurance benefits otherwise payable to me. I also agree to take responsibility for financial obligations related to the dental treatment rendered or any court costs and attorney fees should my account become delinquent.

SIGNATURE: _____ Date: _____