OYSTER POINT DENTAL

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-prescription 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. Novocaines)	❑	❑	Barbiturate	❑	❑	Aspirin	❑	❑
Penicillin or other antibiotics	❑	❑	Sedatives	❑	❑	Latex	❑	❑
Sulfa drugs	❑	❑	Iodine	❑	❑	Other_____		

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		YES	NO		YES	NO
High/Low Blood	❑	❑	Angina/Chest Pain	❑	❑	Liver Disease	❑	❑
Pres. Heart Murmur	❑	❑	Radiation	❑	❑	Heart Trouble	❑	❑
Heart Attack/Disease	❑	❑	Cancer	❑	❑	Respiratory	❑	❑
Rheumatic Fever	❑	❑	Emphysema	❑	❑	Problems Dry Mouth	❑	❑
Fainting / Seizures	❑	❑	Stroke	❑	❑	Ulcers in mouth	❑	❑
Asthma	❑	❑	Arthritis/Osteoporosis	❑	❑	Tuberculosis	❑	❑
Epilepsy / Convulsion	❑	❑	Joint Replacement	❑	❑	Nervous Problems	❑	❑
Leukemia	❑	❑	Hepatitis / Jaundice	❑	❑	Cholesterol	❑	❑
Diabetes	❑	❑	STD's	❑	❑	Bisphosphonates: Prolia, Boniva, Fosamax	❑	❑
Kidney Disease	❑	❑	Stomach Troubles	❑	❑	Sleep Apnea	❑	❑
AIDS / HIV Infection	❑	❑	Hay Fever/Allergies	❑	❑	Premed Antibiotic for Spinal Fusion/ Hip/Joint Replacement	❑	❑
Thyroid problem	❑	❑	Lupus	❑	❑			
Cardiac Pacemaker	❑	❑	Blood Thinners: (Aspirin,Coumadin)	❑	❑			

Medicines, Vitamins & Suppliments:

If there were any "YES" answers, give details: _____

PATIENT DENTAL HISTORY

		YES	NO
1.	Do your gums bleed while brushing or flossing?	❑	❑
2.	Are your teeth sensitive to hot or cold liquids/foods?	❑	❑
3.	Are your teeth sensitive too sweet / sour liquids/foods?	❑	❑
4.	Do you feel pain in any of your teeth?	❑	❑
5.	Do you have any sores or lumps in or near your mouth?	❑	❑
6.	Have you had any head, neck, or jaw injuries?	❑	❑
7.	Have you experienced any of the following problems in your jaw?		
	a) Clicking (pain, difficulty in opening or chewing)?	❑	❑
	b) Pain (joint, ear, side of face)		
	c) Difficulty in opening or closing?	❑	❑

		YES	NO
8.	Do you have frequent headaches?	❑	❑
9.	Do you clench or grind your teeth?	❑	❑
10	Do you bite you lips or cheeks frequently?	❑	❑
11	Have you had any difficult extractions in the past?	❑	❑
12	Have you had any prolonged bleeding following extractions?	❑	❑
13	Have you had any orthodontic therapy? (Braces)	❑	❑
14	Have you ever had instruction on the correct method of brushing your teeth?	❑	❑
15	Have you ever been instructed on the care of your gums?	❑	❑
16	Do you have a Fear of Dentistry?	❑	❑

Rate Fear from 1 to 10 _____

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 Yorktown Dental of the group insurance benefits otherwise payable to me. I also agree to take responsibility for the financial obligations related to the dental treatment rendered or any court costs and attorney fees should your account become delinquent.

SIGNATURE: _____ Date: _____