OYSTER POINT DENTISTRY
General and Cosmetic Dentistry
A DIVISION OF ATLANTIC DENTAL CARE

11848 ROCK LANDING DRIVE, SUITE 301
NEWPORT NEWS, VA 23606
TELEPHONE (757) 596-6211

PATIENT INFORMATION

NAME *(FIRST, MI, LAST)*				PREFERRED NAME/NICKNAME
BIRTH DATE *(MO/DY/YR)*	SEX ☐ MALE ☐ FEMALE	MARITAL STATUS ☐ S ☐ M ☐ D ☐ W ☐ CHILD		SOCIAL SECURITY #
HOME ADDRESS	APT. #	CITY	STATE	ZIP
EMAIL	HOME PHONE	BUSINESS PHONE		CELL PHONE

Occupation: ______

Referred By: ______

DENTAL INSURANCE INFORMATION

Insurance Company Name: ______ Telephone #: ______

Policy ID #: ______ Group#: ______

Policy Holder's Name ______ SS#: ______

Date of Birth: ______ Relationship to Patient: Self ☐ Spouse ☐ Child ☐ Other ☐ ______

Employer: ______

SECONDARY DENTAL INSURANCE INFORMATION

Insurance Company Name: ______ Telephone #: ______

Policy ID #: ______ Group#: ______

Policy Holder's Name ______ SS#: ______

Date of Birth: ______ Relationship to Patient: Self ☐ Spouse ☐ Child ☐ Other ☐ ______

Employer: ______

Medical & Dental History

Are you currently taking any prescription or non-prescription medications? **If yes, please list.**

Please indicate if any of the following apply to you:

- ☐ *TAKE DAILY ASPIRIN
- ☐ *TAKE BLOOD THINNER (Prescription)
- ☐ *TAKE PRE-MED: Amox (for joint Replacement)
- ☐ *TAKE PRE-MED: Other
- ☐ *TAKE PRE-MED: Keflex
- ☐ Allergy: Latex
- ☐ Allergy: Penicillin/Amox
- ☐ Allergy: Sulfa
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ HIV/Auto Immune
- ☐ Jaw Pain
- ☐ Kidney/Liver Disease
- ☐ Mental Disorders
- ☐ Pacemaker
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ None Of The Above

List Other Allergies:

CONTINUED ON BACK ➡

WOMEN ONLY: Are you pregnant?

☐ Yes ☐ No

Within the past year, have there been any changes in your general health?

☐ Yes ☐ No

Please mark any of the following to indicate Yes in response to the question:

☐ Have you ever had complications following dental treatment?

☐ Are you currently under the care of a physician due to a specific condition?

☐ Have you been hospitalized within the last 5 years due to a surgery or illness?

☐ Do you use tobacco (smoking or chewing)?

If any of the previous questions are marked, please explain:

☐ To the best of my knowledge, all of the preceeding information is true and correct. If I ever have a change in my health, I will inform the office at my next dental appointment without fail.

Authorization

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health.

I authorize the diagnosis of my dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed necessary.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or health practitioners. I authorize the payment from my insurance carrier to submit payment directly to the dentist or dental practice to be applied directly to any outstanding balance on my account.

I understand that 24 hours notice is required to cancel or change an appointment or I may be charged a fee.

I understand that all services are payable when rendered. I also understand that I am liable to pay for these services in full even if the insurance carrier pays less than expected. Balances that are sixty (60) days old will have a late charge of 1½% applied to any unpaid balance each month. In the event my account is referred for collection, I agree to pay all reasonable collection and/or attorney fees.

Person Responsible For Account:

Name (Print): ______________________________

Signature: ______________________________ Date: ______________

Relationship to Patient: ______________________________