PATIENT INFORMATION

Patient's Name Last: ______________ First: ______________ Middle Initial: ____
Prefer to be Called: ______________
Soc. Sec #: ______________ DOB: ______________ Sex: M F
Home Phone: ______________ Cell Phone: ______________ Work Phone: ______________
Email: ______________
Address: ______________ City: ______________ State: ______ Zip: ______________

What is the best way to reach you during business hours? Cell Work Home Email
Emergency contact: ______________ Phone: ______________

INSURANCE INFORMATION

Has your insurance changed since the last visit? **Y / N**
If yes:
Responsible Party Name Last: ______________ First: ______________ Middle Initial: ____
Soc. Sec #: ______________ DOB: ______________
Subscriber ID: ______________ Employer: ______________

ACKNOWLEDGEMENT OF PRIVACY PRACTICES

My signature confirms that I have been informed of my rights to privacy regarding my protected personal and health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand the terms in which my personal health and identification information may be used.

I have been informed of my dental provider's *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my protected health information. I have been given the right to review and receive a copy of such *Notice of Privacy Practices*. I understand that my dental provider has the right to change the *Notice of Privacy Practices* and that I may contact this office at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. **Initial** __________

RELATIONSHIP TO PATIENT: ☐ SELF ☐ PARENT ☐ GUARDIAN ☐ OTHER (PLEASE EXPLAIN)

I give permission to receive appointment reminders by Diamond Dental Group via:
☐ Phone ☐ Text Message ☐ E-Mail

PAYMENT/CANCELLATION POLICY

Payment is expected at time of service for all patient co-pays. As a courtesy, we call each person's insurance company to get a breakdown of specific services and benefits. We do our best to provide you with the most accurate treatment estimate according to the benefits given per your insurance. All dental claims will be filed by our office to the insurance company. We know that your time as well as our is very important to us all – with that we are asking that you comply with our new 48-hour cancelation policy. In the event that your appointment is cancelled less than 2 days in advance, or you no-show, your account will be charged $50.00 cancellation/no-show fee. We also understand that things come up that are out of your control so we will waive the first one as a courtesy. **Initial** __________

SIGNATURE: ______________________ **DATE:** ______________

MEDICAL HISTORY UPDATE

PATIENT NAME ______________________ DATE ______________

MEDICAL PHYSICIAN'S INFORMATION

Medical Physician's name ______________ Practice Name ______________

City ______________ State ________ Phone ______________

PREMEDICATION

Have you ever been told by a physician that you need Premedication for Dental Treatment? Y ☐ N ☐

Due to
- ☐ Artificial Heart Valve
- ☐ Previous Endocarditis
- ☐ Congenital Heart Disease
- ☐ Cardiac Transplant
- ☐ Joint Replacement. Date ______________
- ☐ Kidney Disorder
- ☐ Immunocompromised / Immunosupressed

MEDICATIONS

Current Medications & Dosage	For the Treatment Of

DRUG ALLERGIES

Are you allergic or have you had an adverse reaction to any medications? Y ☐ N ☐

- ☐ Latex
- ☐ Penicillin
- ☐ Amoxicillin
- ☐ Sulfa
- ☐ Codeine (Tylenol 3)
- ☐ Hydrocodone (Vicodin)
- ☐ Oxycodone (Percocet)
- ☐ Other: ______________

WOMEN

Are you pregnant? ______________ Expected delivery date ______________

Are you nursing? ______________

TOBACCO USE

Do you currently or have you ever used tobacco? Y ☐ N ☐

Type ______________ Length of time ______________

PLEASE √ Y OR N IF YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST:

	Y	N	N	Y	N		Y	N
Arthritis	☐	☐	Epilepsy	☐	☐	Mitral valve prolapsed	☐	☐
Asthma	☐	☐	GI problems	☐	☐	Obstructive Sleep Apnea	☐	☐
Back problems	☐	☐	Heart disease	☐	☐	Pacemaker	☐	☐
Blood disease	☐	☐	Heart surgery	☐	☐	Psychiatric care	☐	☐
Cancer	☐	☐	Hemophilia	☐	☐	Radiation treatment	☐	☐
Canker sores	☐	☐	Oral herpes (cold sores)	☐	☐	Rheumatic fever	☐	☐
Circulatory problems	☐	☐	Hepatitis B or C	☐	☐	Shingles	☐	☐
Cortisone treatments	☐	☐	High Blood Pressure	☐	☐	Stroke	☐	☐
Diabetes type I	☐	☐	High Cholesterol	☐	☐	Thyroid disease	☐	☐
Diabetes type II	☐	☐	HIV/AIDS	☐	☐	Tonsils removed	☐	☐
Drug addiction	☐	☐	Kidney disease	☐	☐	Tuberculosis	☐	☐
Eating Disorder	☐	☐	Liver Disease	☐	☐	Ulcer	☐	☐

Do you have any disease, condition, or problem not listed here that you feel we should know about?

____

OBSTRUCTIVE SLEEP APNEA

	Y	N
1. Have you been told that you gasp for breath while sleeping?	☐	☐
2. Have you been diagnosed with Obstructive Sleep Apnea?	☐	☐
3. Do you currently use a CPAP?	☐	☐

Patient Signature ______________ Date ______________
(if minor, Parent Signature)

FOR OFFICE USE ONLY

Dentist Signature ______________ Date ______________