Diamond Dental
CARING FOR CHILDREN AND ADULTS

Larry J. Diamond, DDS

"Kids and Adults Love and Trust Us"
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HEALTH HISTORY RECORD

The benefits of a happy, healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

ABOUT YOU

Today's Date:_____

Name: _____

_____

I prefer to be called: _____

Birthdate: _____ ❑ Female ❑ Male

SS#: _____ DL#: _____

Home Address: _____

_____

_____

❑ Single ❑ Married ❑ Other

Hm#:( )_____

Wk#: ( )_____ Ext: _____

Cell#:( )_____ E-mail:_____

Employer: _____

Employer's Address: _____

_____

How long there? _____Occupation:_____

Where & when are the best times for appointments?

M T W TH F T IME:_____ ❑ AM ❑ PM

Other family members seen by us:_____

Previous/Present Dentist:_____
(Please circle)

Phone#: ( )_____Last Visit Date:_____

Whom may we thank for referring you?

_____

SPOUSE INFORMATION

His/Her Name:_____

Employer:_____

Wk#:( )_____Ext:_____DOB:_____

SS#:_____DL#:_____

Neighbor or Relative not living with you.

His/Her Name:_____Relation:_____

Wk#:( )_____Hm#:_____

Address:_____

_____

PRIMARY DENTAL INSURANCE

Insurance Co Name: _____

Address:_____

_____

Insurance Co. Phone#:_____

Group #:(Plan, Local or Policy#)_____

Insured's Name: _____Relation:_____

Insured's Birthdate:_____Insured's SS#:_____

Insured's Employer:_____

Insured's Address:_____

SECONDARY DENTAL INSURANCE

Insurance Co Name: _____

Address:_____

_____

Insurance Co. Phone#:_____

Group #:(Plan, Local or Policy#)_____

Insured's Name: _____Relation:_____

Insured's Birthdate:_____Insured's SS#:_____

Insured's Employer:_____

PERSON RESPONSIBLE FOR ACCOUNT

Name_____

Wk#: ( )_____ Ext: _____ Hm#:_____

Mailing Addres:_____

_____

Relationship:_____

Employer: _____

SS#:_____DL#:_____

FINANCIAL

Payment is due in full at the time of treatment
unless prior arrangements have been approved.

If the office accepts my insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover.

_____

Signature Date

MEDICAL HISTORY

Your current physical health is: ❑ Good ❑ Fair ❑ Poor

Are you currently under the care of a physician? ❑ Yes ❑ No

Please explain: _____

_____

Do you smoke or use tobacco in any other form? ❑ Yes ❑ No

Are you taking any prescription drugs? ❑ Yes ❑ No

Please list: _____

_____

Have you ever take Phen-Fen or Redux? ❑ Yes ❑ No

For Women: Are you taking birth control pills? ❑ Yes ❑ No

Are you pregnant? ❑ Yes ❑ No Week #: _____

Are you nursing? ❑ Yes ❑ No

Have you ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Heart Surgery
Y	N	Alcohol/Drug Abuse	Y	N	Hepatitis
Y	N	Anemia	Y	N	Herpes/Fever Blisters
Y	N	Heart Murmur	Y	N	High Blood Pressure
Y	N	Artificial Bones/Joints/Valves	Y	N	HIV+/AIDS
Y	N	Asthma	Y	N	Kidney Problems
Y	N	Blood Transfusion	Y	N	Liver Disease
Y	N	Cancer/Chemotherapy	Y	N	Low Blood Pressure
Y	N	Colitis	Y	N	Mitral Valve Prolapse
Y	N	Congenital Heart Defect	Y	N	Pacemaker
Y	N	Diabetes	Y	N	Psychiatric Problems
Y	N	Difficulty Breathing	Y	N	Radiation Treatment
Y	N	Emphysema	Y	N	Rheumatic/Scarlet Fever
Y	N	Epilepsy	Y	N	Seizures
Y	N	Fainting Spells	Y	N	Sinus Problems
Y	N	Arthritis	Y	N	Thyroid Problems
Y	N	Glaucoma	Y	N	Tuberculosis
Y	N	Heart Attack	Y	N	Ulcers

Please list any serious medical condition (s) that you have ever had: _____

_____

Are you allergic to any of the following?

Y	N	Aspirin	Y	N	Erythromycin	Y	N	Other
Y	N	Codeine	Y	N	Latex			
Y	N	Dental Anesthetics	Y	N	Penicillin			

Please list any other drugs that you are allergic to: _____

_____

Do you have a personal physician? ❑ Yes ❑ No

Physician's Name: _____

Address: _____

_____

Phone#:( )_____ Date of last visit: _____

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein.

Initials_____ Date_____

Doctors notes: _____

DENTAL HISTORY

What is your primary dental concern(s)?

_____

Are you in pain? ❑ Yes ❑ No

Do you have any fear of dental work? ❑ Yes ❑ No

Date of last dental exam _____

Have you ever had a serious/difficult problem associated with any previous dental work? ❑ Yes ❑ No

Have you ever had gum surgery/deep cleaning? ❑ Yes ❑ No

Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Your current dental health is: ❑ Good ❑ Fair ❑ Poor

Do your gums ever bleed? ❑ Yes ❑ No

How many times a week do you floss? _____

How many times a day do you brush? _____

Do you snore? ❑ Yes ❑ No

Has anyone observed you stop breathing while asleep? ❑ Yes ❑ No

Do you like your smile? ❑ Yes ❑ No

If no, please explain: _____

_____

Would you like fresher breath? ❑ Yes ❑ No

Whiter teeth? ❑ Yes ❑ No

ADULT AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the Dental Office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services I may need, with my prior consent.

I also authorize the Dental Office to release any information, including the diagnosis and records of treatment or examination during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the Dental Office insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf. In the event of payment default for services previously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in an attempt to collect on this amount.

_____

Signature of Patient

Date: _____/_____/_____