The Executive Mews
2300 Computer Avenue, Suite B9-10
Willow Grove, PA 19090

Andrew B. Diamond, DMD, MS
Periodontics and Dental Implants
Diplomate of the American Board of Periodontology

Telephone: (215) 657-2211
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PATIENT INFORMATION

NAME Last, First Middle. PREFERRED NAME SSN#

LOCAL ADDRESS CITY, STATE ZIP DATE OF BIRTH SEX

DRIVER'S LICENSE # STATE EMAIL ADDRESS

TELEPHONE: HOME # / MOBILE # / WORK # / OTHER #

EMERGENCY CONTACT TELEPHONE # / ALT. TELEPHONE # RELATIONSHIP TO PATIENT

PLEASE PLACE A STAR ★ NEXT TO YOUR PREFERRED METHOD OF CONTACT

RESPONSIBLE PARTY INFORMATION (if different from Patient Information)

NAME Last, First Middle. RELATIONSHIP TO PATIENT

DRIVER'S LICENSE # STATE SSN# DATE OF BIRTH SEX

LOCAL ADDRESS CITY, STATE ZIP TELEPHONE # / ALT. TELEPHONE #

PRIMARY DENTAL INSURANCE

NAME OF POLICY HOLDER Last, First Middle. RELATIONSHIP TO PATIENT

POLICY HOLDER'S SSN# POLICY HOLDER'S DATE OF BIRTH

NAME OF INSURANCE COMPANY GROUP # / MEMBER ID #

ADDRESS OF INSURANCE COMPANY CITY, STATE ZIP TELEPHONE #

POLICY HOLDER'S EMPLOYER EMPLOYER'S ADDRESS CITY, STATE ZIP TELEPHONE #

DO YOU HAVE DUAL COVERAGE? YES_____ (see below) NO_____

SECONDARY DENTAL INSURANCE (if applicable)

NAME OF POLICY HOLDER Last, First Middle. RELATIONSHIP TO PATIENT

POLICY HOLDER'S SSN# POLICY HOLDER'S DATE OF BIRTH

NAME OF INSURANCE COMPANY GROUP # / MEMBER ID #

ADDRESS OF INSURANCE COMPANY CITY, STATE ZIP TELEPHONE #

Andrew B. Diamond, DMD, MS, LLC

www.DiamondPeriodontics.com diamondperio1@gmail.com
2300 Computer Ave. | Suite B9-10 • Willow Grove, PA 19090 (215)657-2211

Medical & Dental History Form

Please take a moment to let us know about your medical and dental history so we may serve you more effectively and in a way that watches out for your overall health and well-being.

Patient Name: _____ * _____ * ____ _____
Last First MI Preferred Name

Dentist's name: * _____

What is the reason for your dental visit today?

_____

_____

Pharmacy Name and Location

_____

_____

Your Primary Care Physician's name, address, & phone number? What is the date (or approximate date) of your last medical exam and reason? *

_____

_____

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

- ☐ 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 marijuana (recreational or medical)?
- ☐ Do you consume alcohol?

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

_____

_____

Do you need to pre-medicate prior to dental procedures? * ◯ Yes ◯ No

If yes, with what antibiotic? _____

Please list any medications you are currently taking (including vitamins and supplements):

_____

_____

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

- ☐ Have you ever had complications following dental treatment?
- ☐ Do your gums bleed when you brush or floss?
- ☐ Do your teeth experience sensitivity to cold or hot temperatures?
- ☐ Do you grind your teeth (either consciously or during sleep)?
- ☐ Are any of your teeth loose, or are you concerned about any teeth loosening?

Please indicate if you have experienced any of the following:

- [ ] A- Fib
- [ ] ALS/Lou Gehrig's
- [ ] Acid Reflux
- [ ] Allergy - Aspirin
- [ ] Allergy - Codeine
- [ ] Allergy - Hay Fever
- [ ] Allergy - Latex
- [ ] Allergy - NSAIDs
- [ ] Allergy - Nickel
- [ ] Allergy - Other
- [ ] Allergy - Penicillin
- [ ] Allergy - Shellfish
- [ ] Allergy - Sulfa
- [ ] Anemia
- [ ] Angina Pectoris
- [ ] Anxiety
- [ ] Aortic Stenosis
- [ ] Arteriosclerosis
- [ ] Arthritis
- [ ] Artificial Hrt Valve
- [ ] Artificial Joints
- [ ] Asthma
- [ ] Bi-Pass Surgery
- [ ] Bipolar
- [ ] Blood Disease
- [ ] Blood Transfusion
- [ ] Breastfeeding
- [ ] Bruise Easily
- [ ] Cancer - Breast
- [ ] Cancer- Other
- [ ] Chemotherapy
- [ ] Chewing Tobacco
- [ ] Crohn's disease
- [ ] Depression
- [ ] Diabetes
- [ ] Dizziness/Vertigo
- [ ] Drug Addiction
- [ ] Emphysema/COPD
- [ ] Epilepsy or Seizures
- [ ] Excessive Bleeding
- [ ] Fainting
- [ ] Fibromyalgia
- [ ] Gallbladder
- [ ] Glaucoma
- [ ] HIV
- [ ] Heart Attack
- [ ] Heart Disease
- [ ] Heart Murmur
- [ ] Heart Surgery
- [ ] Hemophilia
- [ ] Hepatitis
- [ ] High Blood Pressure
- [ ] High Cholesterol
- [ ] Hypothyroid
- [ ] IBS
- [ ] Jaundice
- [ ] Kidney Disease
- [ ] Liver Disease
- [ ] MVP
- [ ] Mental Disorders
- [ ] Multiple Sclerosis
- [ ] Narcotic Hx
- [ ] Nervous
- [ ] Osteopenia
- [ ] Osteoporosis
- [ ] PTSD
- [ ] Pacemaker
- [ ] Parkinson's disease
- [ ] Pregnancy
- [ ] Radiation Tx
- [ ] Respiratory Problems
- [ ] Rheumatic Fever
- [ ] Rheumatism
- [ ] Sinus Problems
- [ ] Sjogren's Syndrome
- [ ] Sleep Apnea - CPAP
- [ ] Smoking
- [ ] Stents
- [ ] Stomach Problems
- [ ] Stroke
- [ ] Tuberculosis
- [ ] Tumors
- [ ] Ulcers
- [ ] Vaping
- [ ] Venereal Disease

Do you have any other health issues or allergies not listed above? ◯ Yes ◯ No

if yes, please list:

_____

_____

Consent for Treatment

I, the undersigned, hereby authorize the doctor to take x-rays, photographs, or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of my dental needs. I authorize the doctor to perform all recommended treatment mutually agreed upon by me; and, to use the appropriate medication and therapy indicated for such treatment.

- [ ] *__To the best of my knowledge, all of the preceding 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.__

Response Date: _____

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OFFICE POLICIES

Our office is dedicated to providing you with exceptional service and care while trying to keep the cost to you affordable. We ask your help by understanding and cooperating with our office policies.

Financial Policy

Insurance: It is important to understand that insurance is an agreement between ***you*** and your insurance carrier and that your dental bill for services provided is an agreement between ***you*** and our office.
If we do participate with your insurance, all services will be submitted to your insurance carrier and payments for deductibles, co-insurances and non-covered services are expected at **the time of service.** We will do our very best to estimate your "out-of-pocket" expenses. Any payment not received from your insurance carrier is ***your*** responsibility. Your dental insurance is designed to *help* you pay for your dental treatment. It is not a guarantee payment.
If we do not participate with your insurance, all services will be submitted to your insurance carrier for you, as a courtesy, and payment is expected as services are rendered. You can expect any reimbursement owed to you to come directly from your insurance carrier.

Payment for Services: We accept Visa, Master Card, Discover, American Express, as well as cash or check. There will be a $35 fee for any returned checks. All payments are expected at **the time of service,** unless arrangements are made in advance with our Practice Coordinator. We reserve the right to bill a 1.5 % finance charge (18% APR) on any outstanding balance older than 30 days. ***Patient Initials:*** _____

Appointment Agreement

We understand that your time is very valuable. We make every effort to stay on time so that our patients will not have to wait unnecessarily. Your appointment is a commitment of time between you and our office. We ask that you make every effort to keep that commitment. We do provide a courtesy reminder call/email two to three days prior to your appointment. After receiving your reminder call/email, we **DO** need to hear back from you. If we do not hear back from you, then your appointment is not confirmed, and the appointment time that you had scheduled may be given to another patient who is waiting to be seen by the doctor or dental hygienist.

If you arrive late to your appointment, we may need to reschedule. If you cannot keep your appointment, we require a minimum notice of 48 business hours so we are able to assist other patients with their dental needs. If our office is not notified within 48 business hours, you will be subject to a late cancellation charge of $50 per hour of your scheduled appointment time (i.e. $100 for a 2-hour appointment, etc.).

Patient Initials: _____

Lifetime Signature/Authorization

I request that payment of any and all authorized insurance benefits be made either to me or on my behalf to Andrew B. Diamond, DMD, MS, LLC for professional services rendered. I authorize the use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Patient Initials: _____

I HAVE READ AND FULLY UNDERSTAND THE OFFICE POLICIES SET FORTH AND BY SIGNING BELOW I AGREE TO ALL TERMS.

_____ _____ _____
Signature of Patient and/or Guardian *Printed Name* *Date*

For insurance plans: _____ _____
Name of Policy Holder *Policy Holder's Social Security Number*

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Release Form for Individuals Involved in Care of Patient

I, _____, give Dr. Andrew Diamond's office permission to speak with the following people regarding my health status, including diagnosis, treatment options and plans and payment for health services I receive. This consent is valid until such time as I provide a written revocation of it.

Dr. Diamond's office may speak with:

1.) Primary Care Physician: _____

Phone number: _____

Information to be released: ☐ Treatment ☐ Diagnosis

2.) Other Physicians (i.e. Specialists): _____

Type of Specialty: _____

Phone number: _____

Information to be released: ☐ Treatment ☐ Diagnosis

3.) Name: _____ Relationship: _____

Phone number: _____

Information to be released:

☐ Treatment ☐ Diagnosis ☐ Schedule ☐ Payment ☐ Any

4.) Name: _____ Relationship: _____

Phone number: _____

Information to be released:

☐ Treatment ☐ Diagnosis ☐ Schedule ☐ Payment ☐ Any

Patient Signature: _____ Date: _____

* This form is to be filed in the patient's medical record.