DIAMOND PERIODONTICS
IMPLANT DENTISTRY

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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 #

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

ADDRESS OF INSURANCE COMPANY CITY, STATE ZIP TELEPHONE #

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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

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?

- [ ] 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.__

Signature _____ **Date** _____

Response Date: _____