DIAMOND DENTAL
as distinctive as you are

NEW PATIENT FORM

Patient Information **SELF-PAY / INSURANCE**

Name: _____ **Birthdate:** _____ **SS:** _____

Sex: [ ] Male **[ ]** Female **Phone #:** _____ **Home #:** _____

Address: _____ **City**: _____ **State:** _____ **Zip:** _____

Email: _____

Whom way we thank for referring you? GOOGLE / ZOCDOC / FAMILY / FRIEND: _____

Preferred Pharmacy

Name: _____ **Phone Number:** _____

Street: _____ **Zip:** _____ **City:** _____ **State:** _____

Dental History

Date of last dental care: _____ **Date of last dental X-rays:** _____

Reason for Visit: [ ] Check-Up **[ ]** Tooth Pain **[ ]** Broken Tooth **[ ]** Invisalign

Do you have or have had problems with any of the following?

[ ] Bad Breath **[ ]** Grinding Teeth **[ ]** Sensitivity to Hot or Cold **[ ]** Bleeding Gums

[ ] Bleeding Gums **[ ]** Loose teeth or broken fillings **[ ]** Sensitivity to sweets

[ ] Clicking or popping jaw **[ ]** Sensitivity when biting **[ ]** Food collecting between teeth

[ ] Sores or growths in your mouth

How often do you floss? _____ **How often do you brush?** _____

Medical History

Primary Physician's Name: _____ **Date of last visit:** _____

Have you ever taken any of the group of drugs collectively referred to as "fen-phen?" These include combinations of lonimin, Adipex, Fastin (brand names of phentermine), Pndimin (fenfluramine) and Redux (dexfenfluramine) [ ] Yes [ ] No

Have you ever had any serious illnesses or operation? **[ ]** Yes **[ ]** No

If yes, describe _____

Have you ever had a blood transfusion? **[ ]** Yes **[ ]** No

If yes, give approx. date _____

Women Patient Only

Are you pregnant? [ ] Yes [ ] No **Nursing?** [ ] Yes [ ] No **Taking birth control?** [ ] Yes [ ] No

Do you have or have had problems with any of the following?

[ ] Amenia	**[ ]** Congenital Heart Lesions	**[ ]** Hepatitis	**[ ]** Scarlet Fever
[ ] Arthritis, Rheumatism	**[ ]** Cortisone Treatments	**[ ]** Hernia Repair	**[ ]** Shortness of Breath
[ ] Artificial Heart Valves	**[ ]** Cough, Persistent	**[ ]** High Blood Pressure	**[ ]** Skin Rash
[ ] Artificial Joints, Pins, Etc.	**[ ]** Cough up Blood	**[ ]** HIV/AIDS	**[ ]** Stroke
[ ] Asthma	**[ ]** Diabetes	**[ ]** Jaw Pains	**[ ]** Swelling of Feet
[ ] Back Problems	**[ ]** Epilepsy	**[ ]** Kidney Disease	**[ ]** Thyroid Problems
[ ] Bleeding Abnormally	**[ ]** Fainting	**[ ]** Liver Disease	**[ ]** Tobacco Habits
[ ] Blood disease	**[ ]** Glaucoma	**[ ]** Mitral Valve Prolapse	**[ ]** Tonsillitis
[ ] Cancer	**[ ]** Headaches	**[ ]** Pacemaker	**[ ]** Tuberculosis
[ ] Chemical Dependency	**[ ]** Heart Murmur	**[ ]** Radiation Treatments	**[ ]** Ulcer
[ ] Chemotherapy	**[ ]** Heart Problems	**[ ]** Respiratory Disease	[ ] Venereal Disease
[ ] Circulatory Problems	**[ ]** Hemophilia	**[ ]** Rheumatic fever	

List of Medications you are currently taking:

_____ _____

_____ _____

Allergies:

[ ] None **[ ]** Aspirin **[ ]** Local Anesthetic **[ ]** Iodine **[ ]** Codeine **[ ]** Sleeping Pills **[ ]** Penicillin **[ ]** Latex **[ ]** Sulfa **[ ]** Other: _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my child, ever have a change in health.

_____ _____

Signature of Patient, Parent or Guardian **Date**