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 #

Patient Name:_____ Today's Date:_____ Staff Initials:_____

GP:_____ **THIS AREA FOR OFFICE USE ONLY** BP:_____ P: _____ SPO2:_____

Chief Complaint:_____ Perio/SRP Hx:_____

Currently experiencing any pain? Y N If yes, area/tooth# _____ Pre-Med? Y N Pre-Med Rx: _____

MEDICAL INFORMATION

1. Who is your primary care physician? Physician's Name _____Phone # (_____)_____

   Address _____ Last Visit _____ Reason_____

2. Please list the name, specialty, & phone number of any **medical specialist**(s) you are seeing or have seen in the past two years: _____

   _____

3. Have you been hospitalized during the past two years? YES NO If yes, list the reason:_____

4. Are you currently taking any medication or drugs? (include **over-the-counter:** i.e. **aspirin**, **vitamins** & **supplements**) …….. YES NO

   If yes, please list, use back of page if necessary: _____

5. Pharmacy Name: _____ Location: _____ Phone #: _____

6. Are you sensitive or allergic to any medication or anesthetics? ……..... YES NO

   If yes, please list: _____

7. Indicate which of the following you have had or have at present. Circle "YES" or "NO" for each item:

Heart Failure……..	YES	NO	Artificial Joints(hip,knee,etc)	YES	NO	Allergy to Latex…..…… .	YES	NO
Heart Disease or Attack… ...	YES	NO	Kidney Trouble…….. ..	YES	NO	Hepatitis B (serum)…….....	YES	NO
Angina Pectoris……..….	YES	NO	Ulcers……..	YES	NO	Venereal Disease……..….	YES	NO
Congenital Heart Disease…	YES	NO	Diabetes……..	YES	NO	A.I.D.S……..….	YES	NO
Heart Murmur…….	YES	NO	Thyroid Problems……..….	YES	NO	H.I.V. Positive……..….	YES	NO
High Blood Pressure…….	YES	NO	Glaucoma……..….	YES	NO	Cold Sores/Fever Blisters...	YES	NO
Arteriosclerosis……..	YES	NO	Cancer……..….	YES	NO	Blood Transfusion…….....	YES	NO
Mitral Valve Prolapse……	YES	NO	Emphysema……..….	YES	NO	Hemophilia……..….	YES	NO
Artificial Heart Valve…….	YES	NO	Chronic Cough……..….	YES	NO	Anemia……..….	YES	NO
Heart Pacemaker……..	YES	NO	Tuberculosis……..	YES	NO	Sickle Cell Disease……...	YES	NO
Heart Surgery……..	YES	NO	Asthma……..….	YES	NO	Bruise Easily……..	YES	NO
Rheumatic Fever…….	YES	NO	Hay Fever……..….	YES	NO	Liver Disease……..	YES	NO
Arthritis……..	YES	NO	Allergies or Hives..……	YES	NO	Yellow Jaundice……..	YES	NO
Rheumatism……..	YES	NO	Sinus Trouble……..	YES	NO	Epilepsy or Seizures……	YES	NO
Cortisone Medication……	YES	NO	Radiation Therapy……..…	YES	NO	Fainting or Dizzy Spells…..	YES	NO
Drug Addiction……..	YES	NO	Chemotherapy……..….	YES	NO	Nervousness……..	YES	NO
Stroke……..	YES	NO	Hepatitis A (infectious)…...	YES	NO	Tumors……..….	YES	NO
						Developmentally Disabled..	YES	NO

8. Do you have or have you had any disease, condition, or problem not listed?..... YES NO

   If yes, please list: _____

9. Have you ever been diagnosed with sleep apnea? YES NO If yes, how is it being treated? _____

10. Have you used tobacco or vape products in the last year? YES NO If yes, how much per day? _____

11. Do you consume alcohol? YES NO If yes, how much per day or week?_____

FOR WOMEN ONLY: Circle your answer

Are you pregnant? YES NO What trimester?_____ Are you nursing? YES NO Are you taking birth control pills? YES NO

Additional Information: _____

_____

CONSENT FOR TREATMENT

I, the undersigned, understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge. I understand that it is my responsibility to advise your office of any changes in the information contained on this form.

I, the undersigned, also hereby authorize the doctor to take x-rays, study models, 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. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide the recommended treatment.

Patient Signature_____ Date_____ Witness_____

Parent or Responsible Party_____ Relationship to Patient_____

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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 as well as cash or check. There will be a $20 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 $50 late cancellation charge.

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.