DIAMOND
DENTAL STUDIO
THE CARE YOU DESERVE
JULIA K. MIKELL, DDS

WELCOME NEW PATIENTS

We are happy to have you as new patient in our practice. We want to help you fulfill your desire to have a healthy mouth, attractive smile, and maintain your mouth that way for the rest of your life. The more informed you are, the better we can communicate to meet your treatment needs and expectations. Ask us questions!

Our aim is to provide excellent dentistry in a compassionate and comfortable setting.

Please complete ALL sections on this form.

PATIENT INFORMATION

Legal First Name: _____ Preferred Name: _____

Legal Last Name: _____ Middle Initial: _____ Marital Status: _____

Date of Birth: _____/_____/_____ Social Security Number: _____ Sex: ◯Male ◯Female

Mailing Address: _____

Cell Phone:(_____)_____-_____ Home Phone:(_____) _____-_____ Other: (_____) _____-_____

Email Address: _____ Referred By: _____

Employer: _____ Driver's License Number: _____ State: _____

Emergency Contact: _____ Phone:(_____)_____-_____

Primary Doctor: _____ Phone:(_____)_____-_____

Preferred Pharmacy & Location: _____ Phone #: (_____) _____-_____

RESPONSIBLE PARTY: *Only complete if different from patient information above*.

First Name: _____ Last Name: _____ Sex: ◯Male ◯Female

Date of Birth: _____/_____/_____ Social Security Number: _____ Driver's License #:_____

Mailing Address: _____

Cell Phone: (_____) _____-_____ Home Phone: (_____) _____-_____ Other: (_____) _____-_____

INSURANCE

Policyholder Name: _____ SSN or ID #: _____

Policyholder Date of Birth: _____/_____/_____ Relation to patient_____

PRIMARY DENTAL INSURANCE:

Insurance Company: _____ Phone #: (_____) _____-_____

SSN or ID #: _____ Employer: _____ Group Number: _____

SECONDARY DENTAL INSURANCE: (If applicable)

Subscriber Name: _____ Subscriber Date of Birth: _____/_____/_____

Insurance Company: _____ Phone #: (_____) _____-_____

SSN or ID #: _____ Employer: _____ Group Number: _____

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APPOINTMENT GUIDELINES

Broken and cancelled appointments are very costly to our practice and prevent someone in need of treatment from receiving care. Please be aware that we do not double book appointments, so your reserved appointment time is exclusively yours! If you are unable to keep your appointment, please give at least a 24-hour notice so that we may extend the offer to another patient. Failure to cancel at least 24 hours prior may result in up to a $50.00 charge for each missed appointment.

METHODS OF PAYMENT:

➢ Cash, Check, all major credit cards, and Care Credit (3rd party financing that allows you to start treatment right away and spread payments out over time). ***We do not offer in-house financing.***

INSURANCE INFORMATION:

➢ We would like to emphasize that our relationship is with you and not your insurance company. While we are happy to file insurance claims as a courtesy to you, we ask that your estimated co-payments and deductibles be paid at the time of service. Please remember that the numbers we give you are an ESTIMATE and sometimes, not everything is covered by insurance as estimated. You are responsible for payment of all services regardless of the payable benefit from your insurance.

PAYMENT IS DUE AT THE TIME OF SERVICE.

I have read and understand the office guidelines that are stated above.

NAME (Printed) SIGNATURE DATE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

*** You May Refuse to Sign This Acknowledgement***

I have received a copy of the Notice of Privacy Practices.

NAME (Printed) SIGNATURE DATE

Notice of Privacy Practices are posted in reception area near office window.
You may also request a copy of our office's Privacy Practices for your records.

For Office Use Only:
We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:
Individual refused to sign // Communications barriers prohibited obtaining the acknowledgement // An emergency situation prevented us from obtaining acknowledgement
Other (Please Specify) : _____

X-RAY RELEASE FORM

I, _____, give permission for your office to transfer any x-rays by email to/from the dental office of Dr. Julia Mikell at care@diamonddentalcolumbia.com

Patient Name: _____ Date of Birth: _____

Signature: _____ Today's Date: _____

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3261 Harrison Road
Columbia, SC 29204
803-738-1114
care@diamonddentalcolumbia.com

AUTHORIZATION – COMPOUND TREATMENT

This authorization form permits the office of Diamond Dental Studio to use or disclose protected health information listed below.

Please COMPLETE this form.

Please check all forms we may use to contact you.

CELL PHONE: ◯Call ◯Text ◯Leave Message ◯ Appointment Information

HOME PHONE: ◯Call ◯Leave Message ◯ Account/Financial Information

EMAIL: ◯YES ◯NO

AUTHORIZATION TO COMMUNICATE WITH SPOUSE/FAMILY

This authorization shall be enforced until revoked by the patient (in writing). This practice will verify the identity of any entity requesting protected health information.

I authorize the release of information including appointment confirmation and the diagnosis, records, examination rendered to me, account information and claims information. The information may be released to:

NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER
NAME	RELATIONSHIP	PHONE NUMBER

Rights of the Patient

I understand I have the right to revoke this authorization at any time by sending a written notification to the address listed on this form. I understand that a revocation is not effective in cases where the information has already been used or disclosed but will be effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

NAME (Printed) SIGNATURE DATE

MEDICAL HISTORY

Are you under a physician's care now?	◯ Yes ◯ No	If yes
Have you ever been hospitalized or had a major operation?	◯ Yes ◯ No	If yes
Have you ever had a serious head or neck injury?	◯ Yes ◯ No	If yes
Are you taking any medications, pills, or drugs?	◯ Yes ◯ No	If yes
Do you take, or have you taken, Phen-Fen or Redux?	◯ Yes ◯ No	If yes
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	◯ Yes ◯ No	If yes
Are you on a special diet?	◯ Yes ◯ No	
Do you use tobacco?	◯ Yes ◯ No	

Women: Are you...

☐ Pregnant/Trying to get pregnant? ☐ Nursing? ☐ Taking oral contraceptives?

Are you allergic to any of the following?

☐ Aspirin	☐ Penicillin	☐ Codeine	☐ Acrylic
☐ Metal	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics

Do you use controlled substances?	◯ Yes ◯ No	If yes	
Other?	☐	If yes	

Do you have, or have you had, any of the following?

AIDS/HIV Positive	◯ Yes ◯ No	Cortisone Medicine	◯ Yes ◯ No	Hemophilia	◯ Yes ◯ No	Radiation Treatments	◯ Yes ◯ No
Alzheimer's Disease	◯ Yes ◯ No	Diabetes	◯ Yes ◯ No	Hepatitis A	◯ Yes ◯ No	Recent Weight Loss	◯ Yes ◯ No
Anaphylaxis	◯ Yes ◯ No	Drug Addiction	◯ Yes ◯ No	Hepatitis B or C	◯ Yes ◯ No	Renal Dialysis	◯ Yes ◯ No
Anemia	◯ Yes ◯ No	Easily Winded	◯ Yes ◯ No	Rheumatic Fever	◯ Yes ◯ No	Angina	◯ Yes ◯ No
Emphysema	◯ Yes ◯ No	High Blood Pressure	◯ Yes ◯ No	Rheumatism	◯ Yes ◯ No	Arthritis/Gout	◯ Yes ◯ No
Epilepsy or Seizures	◯ Yes ◯ No	High Cholesterol	◯ Yes ◯ No	Scarlet Fever	◯ Yes ◯ No	Artificial Heart Valve	◯ Yes ◯ No
Excessive Bleeding	◯ Yes ◯ No	Hives or Rash	◯ Yes ◯ No	Shingles	◯ Yes ◯ No	Artificial Joint	◯ Yes ◯ No
Excessive Thirst	◯ Yes ◯ No	Hypoglycemia	◯ Yes ◯ No	Sickle Cell Disease	◯ Yes ◯ No	Asthma	◯ Yes ◯ No
Fainting Spells/Dizzness	◯ Yes ◯ No	Irregular Heartbeat	◯ Yes ◯ No	Sinus Trouble	◯ Yes ◯ No	Blood Disease	◯ Yes ◯ No
Frequent Cough	◯ Yes ◯ No	Kidney Problems	◯ Yes ◯ No	Spina Bifida	◯ Yes ◯ No	Blood Transfusion	◯ Yes ◯ No
Frequent Diarrhea	◯ Yes ◯ No	Leukemia	◯ Yes ◯ No	Stomach/Intestinal Disease	◯ Yes ◯ No	Breathing Problems	◯ Yes ◯ No
Frequent Headaches	◯ Yes ◯ No	Liver Disease	◯ Yes ◯ No	Stroke	◯ Yes ◯ No	Bruise Easily	◯ Yes ◯ No
Low Blood Pressure	◯ Yes ◯ No	Swelling of Limbs	◯ Yes ◯ No	Cancer	◯ Yes ◯ No	Glaucoma	◯ Yes ◯ No
Lung Disease	◯ Yes ◯ No	Thyroid Disease	◯ Yes ◯ No	Chemotherapy	◯ Yes ◯ No	Hay Fever	◯ Yes ◯ No
Mitral Valve Prolapse	◯ Yes ◯ No	Tonsillitis	◯ Yes ◯ No	Chest Pains	◯ Yes ◯ No	Heart Attack/Failure	◯ Yes ◯ No
Osteoporosis	◯ Yes ◯ No	Tuberculosis	◯ Yes ◯ No	Cold Sores/Fever Blisters	◯ Yes ◯ No	Heart Murmur	◯ Yes ◯ No
Pain in Jaw Joints	◯ Yes ◯ No	Tumors or Growths	◯ Yes ◯ No	Congenital Heart Disorder	◯ Yes ◯ No	Heart Pacemaker	◯ Yes ◯ No
Parathyroid Disease	◯ Yes ◯ No	Ulcers	◯ Yes ◯ No	Convulsions	◯ Yes ◯ No	Heart Trouble/Disease	◯ Yes ◯ No
Psychiatric Care	◯ Yes ◯ No	Yellow Jaundice	◯ Yes ◯ No				

Have you ever had any serious illness not listed above?	◯ Yes ◯ No	If yes

Comments/More Info:

NAME (Printed) SIGNATURE DATE

DENTAL HISTORY

Please take a minute to answer these questions as thoroughly as possible so we can properly assess your dental needs.

When was your last dental exam? _____

What was the purpose of the visit? _____

Name, location and phone # of previous Dentist so we can check on last x-rays taken:

_____

Please check Yes or No for the following questions:

Are you currently experiencing dental pain – either tooth or jaw? ◯Yes ◯No

Do you experience jaw popping? ◯Yes ◯No ; Locking of Jaw? ◯Yes ◯No ; Soreness upon waking? ◯Yes ◯No

Do you or have you ever been told you clench or grind your teeth? ◯Yes ◯No

Do you have a night guard? ◯Yes ◯No ; If yes, do you use it? ◯Yes ◯No

Have you ever had braces? ◯Yes ◯No ; If yes, what year? _____

Ever been told you have periodontal (gum) disease? ◯Yes ◯No ; If yes, when? _____

Ever had injury to the mouth or jaw? ◯Yes ◯No; If yes, describe:

_____

Please check the box for the following questions:

Chew gum? ☐All day ☐Weekly ☐On occasion ☐Never

Do you have sensitive teeth? ☐Yes ☐No (Circle one) Hot Cold Sweets Biting.

Have you been told you snore? ☐Yes ☐No

Do you bite your fingernails? ☐Yes ☐No

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

Drink soft drinks, sweet teas, coffee with creamers? ☐All day ☐AM ☐Weekly ☐ Occasionally ☐Never

How often do you brush? ☐Not regularly ☐1x/day ☐2x/day ☐3x/day

Use electric toothbrush? ☐Yes ☐No

Do you floss? ☐Never ☐Weekly ☐Daily ☐After every meal

Do you use toothpicks? ☐Yes ☐No

Do you use mouth rinse? ☐Yes ☐No (Circle one) AM PM ; Brand:_____

Do you have concerns regarding your teeth or smile? _____

_____