



# 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: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## DENTAL INSURANCE – We cannot file Medical or RX 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: \_\_\_\_\_



**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.**

*Appointments must be confirmed 1 week prior to appointment date.*

*If your appointment is not confirmed, we reserve the right to offer that appointment to a patient in need.*

**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). If your account is sent to collections for non-payment there will be a 40% charge.

***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.

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NAME (Printed)	SIGNATURE	DATE
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**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.

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NAME (Printed)	SIGNATURE	DATE
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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: \_\_\_\_\_



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
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NAME	RELATIONSHIP	PHONE NUMBER
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NAME	RELATIONSHIP	PHONE NUMBER
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### 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
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# MEDICAL HISTORY

Are you under a physician's care now?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 95%;" type="text"/>
Have you ever been hospitalized or had a major operation?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 95%;" type="text"/>
Have you ever had a serious head or neck injury?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 95%;" type="text"/>
Are you taking any medications, pills, or drugs?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 95%;" type="text"/>
Do you take, or have you taken, Phen-Fen or Redux?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 95%;" type="text"/>
Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates?	<input type="radio"/> Yes <input type="radio"/> No	If yes	<input style="width: 95%;" type="text"/>
Are you on a special diet?	<input type="radio"/> Yes <input type="radio"/> No		
Do you use tobacco?	<input type="radio"/> Yes <input type="radio"/> No		

Women: Are you...

<input type="checkbox"/> Pregnant/Trying to get pregnant?	<input type="checkbox"/> Nursing?	<input type="checkbox"/> Taking oral contraceptives?
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Are you allergic to any of the following?

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

\_\_\_\_\_