

Diamond Dental WELCOME

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be glad to help.

(Please print)

DATE: _____

NAME: _____

BIRTHDAY: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

SEX: FEMALE/MALE SOCIAL SECURITY #: _____

HOME PHONE: _____ CELL PHONE: _____

EMAIL: _____ DO YOU PREFER: TEXT/CALL CELL/CALL HOME

ARE YOU (CIRCLE ONE): MARRIED SINGLE MINOR

EMERGENCY CONTACT: _____ RELATION/PHONE: _____

DENTAL HISTORY

FORMER DENTIST: _____ PHONE#: _____

DATE OF LAST XRAY: _____ DATE OF LAST DENTAL VISIT: _____

PLEASE CIRCLE ALL THAT APPLY

BAD BREATH	LOOSE TEETH/BROKEN FILLINGS	SENSITIVITY TO SWEETS	TOOTH PAIN
BLEEDING GUMS	JAW, HEAD, NECK INJURIES	SENSITIVITY TO BITIN	LIP OR CHEEK BITING
PAIN AROUND EAR	BLISTERS ON LIPS/GUMS	FREQUENT HEADACHES	SENSITIVITY TO HEAT
FINGERNAIL BITING	JAW DIFFICULTY: CLICKING/PAIN	GRINDING TEETH	SENSITIVITY TO COLD

I hereby authorize and request the performance of dental services for myself and my dependents and further the performance of whatever procedure the judgment of the named Doctor may consider necessary during the performance of any operation. In addition, I also authorize the administration of whatever anesthetics or analgesics which the Doctor deems advisable during the rendering of care. I also authorize any pictures be taken when necessary. (Initials) _____