Welcome!

Victor Diamond DMD, PC
700 Attucks Lane Suite 2B
Hyannis MA 02601
508-771-4555 (O)
508-771-6656 (F)

To help us meet all your dental healthcare needs, please fill out this form completely in ink.
If you have any questions or need assistance, please ask us - we will be happy to help.

Patient Information (CONFIDENTIAL) Date_____

Birthdate_____

Name_____ Soc. Sec._____

Home Phone_____ Cell Phone_____

Mailing Address_____ City_____ State_____ Zip_____

Home Address_____ City_____ State_____ Zip_____

Check Appropriate Box ☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

☐ Male ☐ Female

If Student, Name of School/College_____ City_____ State_____ ☐ Full-time ☐ Part-time

Patient's or Parent's Employer_____ Work Phone_____

Business Address_____City_____State_____Zip_____

Spouse or Parent's Name_____ Employer_____ Work Phone_____

Whom May We Thank for Referring You? _____

Person to Contact in Case of Emergency_____ Phone_____

Responsible Party

Name of Person Responsible for this Account_____ Relationship to Patient_____

Address_____ Home Phone_____

Driver's License #_____ Birthdate_____

Employer_____ Work Phone_____ SSN#_____

Is This Person Currently a Patient in our Office? ☐ Yes ☐ No

Insurance Information

Name of Insured_____ Relationship to Patient_____

Birthdate_____ SSN#_____ Date Employed_____

Name of Employer_____ Union or Local #_____Work Phone_____

Address of Employer_____ City_____ State_____ Zip_____

Insurance Company_____ Group #_____Policy/ID #_____

Ins. Co. Address_____ City_____ State_____ Zip_____

Over Please

1. Are you having pain or discomfort at this time? ..... YES NO
2. Have you been a patient in the hospital during the past two years? .....YES NO
3. Have you been under the care of a medical doctor during the past two years? .....YES NO
   Physicians Name_____ Phone No._____
   Address_____
4. Have you taken any medication or drugs during the past two years? .....YES NO
5. Are you now taking any medications or drugs? .....YES NO
If yes please list _____
6. Are you aware of being allergic to or have you ever reacted adversely to any medication or substance?. Y N
If yes please list _____

7. Indicate which of the following you have had or have at present. Circle "yes" or "no" to each item.

Heart Failure.....YES NO
Heart Disease or Attack. YES NO
Angina Pectons.....YES NO
Cong. Heart Disease…...YES NO
Heart Murmur.....YES NO
High Blood Pressure.....YES NO
Art. Heart Valve.....YES NO
Heart Pacemaker.....YES NO
Heart Surgery.....YES NO
Rheumatic Fever.....YES NO
Arthritis.....YES NO
Cortisone Medicine……YES NO
Drug Addiction.....YES NO
Stroke.....YES NO
Artificial Joints (hip, knee, etc.)…….....YES NO
Kidney Trouble.....YES NO

Ulcers.....YES NO
Diabetes.....YES NO
Thyroid Problems.....YES NO
Glaucoma…….....YES NO
Cosmetic Surgery.....YES NO
Emphysema.....YES NO
Chronic Cough.....YES NO
Tuberculosis.....YES NO
Asthma.....YES NO
Hay Fever.....YES NO
Allergies or Hives.....YES NO
Sinus Trouble.....YES NO
Radiation Therapy.....YES NO
Chemotherapy.....YES NO
Hepatitis A (infectious)..YES NO
Hepatitis B (serum).....YES NO
Venereal Disease.....YES NO
A.I.D.S.....YES NO

H.I.V. Positive.....YES NO
Cold Sores/Fever Blisters.....YES NO
Blood Transfusion.....YES NO
Hemophilia.....YES NO
Anemia.....YES NO
Sickle Cell Disease.....YES NO
Bruise Easily.....YES NO
Liver Disease.....YES NO
Yellow Jaundice.....YES NO
Epilepsy or Seizures.....YES NO
Fainting or Dizzy Spells.....YES NO
Nervousness.....YES NO
Psychiatric Treatment.....YES NO
Developmental Disability.....YES NO
Cancer.....YES NO

8. **FOR WOMEN ONLY**

Are you pregnant? ☐ Yes, what month? _____ ☐ No Are you nursing? ☐ Yes ☐ No
Are you taking birth control pills? ☐ Yes ☐ No

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions truthfully and to the best of my knowledge.

X Patient
Signature_____Date_____

History Review

_____

_____

_____

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_____

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Doctor's Signature_____Date_____