



Name: _____

DOB: ____/____/____

Health History

CARDIOVASCULAR (HEART)

- High blood pressure (hypertension)
- Irregular heart beat, pacemaker
- Chest pain (Angina)
- Heart attack (MI)
- Heart murmur, Mitral valve prolapse
- Prosthetic heart valve
- Heart surgery (bypass, transplant, stent)

PULMONARY (LUNGS)

- Asthma
- Emphysema, bronchitis
- Pneumonia
- Tuberculosis

NERVOUS SYSTEM

- Alzheimer's disease or other dementia
- Depression, phobia or severe anxiety disorder
- Seizure/ epilepsy
- Headaches, frequent or severe
- Stroke (CVA)
- Degenerative disorders or paralysis (Parkinson's, MS, Cerebral Palsy, etc.)

DERMATOLOGY (SKIN)

- Rash/ hives/ sores
- Skin pathology: _____

HEMATOLOGIC (BLOOD)

- Anemia
- Bleeding disorder
- Bone marrow or stem cell transplant
- Blood transfusion
- Leukemia, blood cancer, lymphoma, multiple myeloma

GASTROINTESTINAL (DIGESTIVE)

- Hepatitis
- Cirrhosis
- Ulcer(s)
- Irritable bowel
- Crohn's or ulcerative colitis
- Transplant: liver, kidney
- Heart burn (reflux)

GENITOURINARY (KIDNEYS)

- Dialysis
- Syphilis, gonorrhea, herpes

MUSCULOSKELETAL

- Artificial joint
- Degenerative arthritis
- Rheumatoid arthritis
- Osteoporosis
- Treated with drugs for osteoporosis

ENDOCRINE

- Diabetes: _____
- Thyroid: hyper hypo
- Prostate problems
- Adrenal disorder
- Corticosteroid therapy

IMMUNE SYSTEM

- Allergy to food, metals or jewelry
- HIV or AIDS
- Lupus
- Sjogren's syndrome

CANCER

- ANY history of cancer
- EXPLAIN: _____
- _____
- Radiation Chemotherapy
- Surgery: _____

WOMEN

- I am pregnant or possibly pregnant
- I am nursing
- Post-menopause
- Contraceptive
- OTHER ILLNESS: _____

FOR DOCTOR USE ONLY:

- Aspirin: Dosage: _____
- Coumadin: Recent INR _____
- Plavix: Recent INR _____
- Oral/ IV bisphosphonates _____
- Antibiotic prophylaxis _____
- Smoking: _____
- Sinus problems: _____
- Penicillin allergy _____
- Aspirin allergy _____
- Codeine/ narcotic allergy _____
- Latex allergy _____
- Diabetes _____
- MD consultation: _____
- NOTES/OTHER: _____
- _____
- _____
- _____
- _____

Have you been hospitalized during the past 2 years? Please explain:

Physician: _____ Tel: _____
 Do you have any health problems that need further clarification?

Medications

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

The above medical history has been reviewed with me and to the best of my knowledge the recordings are complete and accurate. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN _____

DATE _____



GREG R. DIAMOND, DDS
MARK SCHLESINGER, DDS

PERIODONTICS, AESTHETIC AND IMPLANT DENTISTRY

Name: _____

Primary Dental Insurance

Who is responsible for this account? _____ Relationship to Patient _____

INSURANCE CO. _____ PATIENT SS/ ID # _____

GROUP # _____ PATIENT'S EMPLOYER _____

IF THE INSURANCE SUBSCRIBER IS NOT THE PATIENT, PROVIDE INFORMATION BELOW:

SUBSCRIBER'S ADDRESS (if different) _____

SUBSCRIBER'S ID/ SS # _____ SUBSCRIBER'S D.O.B. _____

SUBSCRIBER'S EMPLOYER _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ and assign directly to Greg R. Diamond DDS/ Mark Schlesinger, DDS all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Greg R. Diamond DDS/ Mark Schlesinger, DDS may use my health care information and may disclose such information to the above named Insurance Company and their agents for the purpose of obtaining payment for services rendered and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below, whichever occurs later.

 Signature of Patient, Parent, Guardian or Personal representative

 Date

Secondary Dental Insurance

Who is responsible for this account? _____ Relationship to Patient _____

INSURANCE CO. _____ PATIENT SS/ ID # (If different from above) _____

GROUP # _____

IF THE INSURANCE SUBSCRIBER IS NOT THE PATIENT, PROVIDE INFORMATION BELOW ONLY IF DIFFERENT FROM ABOVE:

SUBSCRIBER'S ADDRESS _____

SUBSCRIBER'S ID/ SS # _____ SUBSCRIBER'S D.O.B. _____

SUBSCRIBER'S EMPLOYER _____

Financial Agreement

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time services are rendered, or within five (5) days of billing if credit shall be extended, unless other financial arrangements are made. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of the patient must be determined before treatment.

I agree that parents or guardians are responsible for all fees and services rendered for treatment of a minor/ child.

All emergency or urgent dental services, or any dental services performed without previous financial arrangements, must be paid for at the time services are performed.

Dental Insurance Benefits: Patients who carry dental insurance plans that the Doctor does not participate with understand that all dental services furnished are charged directly to the patient and that he/ she is personally responsible for payment. We will gladly help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. We cannot render services under the assumption that our charges will be paid by an insurance company. I understand that filing a claim with my insurance company does not relieve me of my responsibility for payment of all charges.

A service charge of 1.5% per month (18% annum) on the unpaid balance may be charged on all accounts exceeding 60 days, unless previous arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

I further agree that waiver or breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. I grant permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form. I have read and understood the above conditions of treatment and payment and agree to their content.

 Signature of Patient, Parent, Guardian or Personal representative

 Date



GREG R. DIAMOND, DDS
MARK SCHLESINGER, DDS

PERIODONTICS, AESTHETIC AND IMPLANT DENTISTRY

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that health providers keep your medical and dental information private. The HIPAA privacy rule states that health providers must also provide patients with a written Notice of Privacy Practices. This notice is dated January 2008. The Privacy Practices described will be in effect after this date and until or if they are replaced. You may obtain additional copies of this Notice upon request.

Uses and Disclosure of Information

Treatment Services

We may use or provide your health information to all of our staff members, other dentists, your physicians, and/or other healthcare providers taking care of you. We may also provide mail, phone or electronic contacts as appointment reminders, recommendations of treatment alternatives, information about other health services and/or other office services.

Payment and Operations

We may provide your health information as required to allow for payment for services and participation in quality assurance, disease management, training, licensing, and certification programs.

Marketing

We will not use your health information for marketing purposes without your written consent.

Legal Requirements

We may disclose your health information when required by law.

Threat to Health and Safety

If abuse or neglect is reasonably suspected, we may disclose your health information to the appropriate governmental authorities.

National Security

When required, we may disclose military personnel with health information to the Armed Forces. Information may be given to authorized federal official when required for intelligence and national security activities.

Family Members, Friends, and Others Involved in Care

At your request, we may disclose your health information to a family member or other person if necessary to assist with your treatment and/or payment for services. Based on our judgment and as per 164.522(a) of HIPAA we may disclose your information to these persons in the event of an emergency situation. We also may make information available so that another person may pick up filled prescriptions, medical supplies, records, or x-rays for you. Your information may be disclosed to assist in notifying a family member, care-giver, or personal representative of your location or condition.

Patient Rights

You have the right to see your information and receive copies of your records under most circumstances. Your request must be in writing addressed to the contact officer. You may be charged for the cost of making copies including the actual copies and staff time. Postage will be added if copies are requested to be mailed. A summary of your health information can also be requested for a fee.

You may request a listing of any situations where we or our business associates disclosed your health information for purposes other than treatment, payment, or other activities for the last six years. You may be charged for costs associated with our response.

You may request that we observe additional restrictions on the disclosure of your information. We are not required to agree to these restrictions, but we may do so (except in case of an emergency).

If you believe that changes should be made to your health information, you must request this in writing. You must provide an explanation as to why changes should be made. Even with your request, changes may be refused under certain circumstances.

If you would like to receive your health information in an alternate format or at a specified location you must make your request in writing.

Acknowledgement of Receipt of Notice of Privacy Practices

By signing this form I confirm that I have had the opportunity to receive a copy of the Notice of Privacy Practices.

PRINT NAME _____

SIGN NAME _____ DATE _____



GREG R. DIAMOND, DDS
MARK SCHLESINGER, DDS

PERIODONTICS, AESTHETIC AND IMPLANT DENTISTRY

Dear Patient

Thank you for selecting us as your personal Dental Care Team. We are confident that your relationship with us will be pleasant.

Our office policy is that all dental treatment be paid for at the time of service. For your convenience, we welcome all major credit cards. In cases where your treatment is completed or your balance remains unpaid, we may charge your credit card.

Kindly provide your endorsement and credit card number with the expiration date. In addition we will need the VIN number located on the back of your card above the signature.

Sincerely,

Greg R. Diamond, DDS
Mark Schlesinger, DDS

Credit Card Authorization

This signature authorizes my unpaid completed dental treatment to be charged in full by:

VISA MasterCard American Express Discover

CC# _____ VIN# _____ Exp. Date ____/____/____

VISA MasterCard American Express Discover

CC# _____ VIN# _____ Exp. Date ____/____/____

Cancellation Policy

We understand that emergencies happen and personal circumstances may prevent you from keeping a doctor's appointment. We ask you to show consideration by calling well in advance if you are unable to keep an appointment. We would like to have the option to offer that appointment to another patient who needs to see the doctor.

We will dismiss the first time you fail to be present at your scheduled appointment. However, further failure to be present at your scheduled appointment can result in a charge of 50% of the planned services. This charge cannot be billed to the insurance company. Failure to pay a no show fee will be treated according to our policy on unpaid balance.

I have read and understood the cancellation policy and agree to make my best effort to abide by the terms.

SIGNATURE OF PATIENT, PARENT OR GUARDIAN

DATE