Campbell Family & Cosmetic Dentistry

Patient Information

Patient Name: _____ Date:_____
Last First MI (Preferred Name)

Gender: _____ Marital Status: S M D W Child

Social Security #: _____ Birth Date: ___/___/____

Phone (Home): _____ (Cell): _____

(Work): _____ Ext: _____ Email: _____

Best place for confirmation calls: Home ____ Cell____ Work___ May we leave a message at: Home ___ Cell ___ Work ___

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Date of Last Dental Visit: _____ Reason for today's visit: _____

Have you ever had any of the following? Please check those that apply:

- ☐ ADD / ADHD
- ☐ AIDS / HIV
- ☐ Allergies _____ _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Codeine Allergy
- ☐ Diabetes
- ☐ Dizziness
- ☐ Epilepsy
- ☐ Excessive Bleeding
- ☐ Fainting
- ☐ Glaucoma
- ☐ Growths
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Hepatitis A__ B__C__
- ☐ High Blood Pressure
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Latex Allergy
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Nervous Disorders
- ☐ Pacemaker
- ☐ Penicillin Allergy
- ☐ Currently Pregnant Due date:_____
- ☐ Radiation Treatment
- ☐ Respiratory Problems
- ☐ Rheumatic Fever
- ☐ Rheumatism
- ☐ Sinus Problems
- ☐ Smoker
- ☐ Stomach Problems
- ☐ Stroke
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Ulcers
- ☐ Venereal Disease

OTHER:
☐ _____

_____

- Have you ever had a history of drug or alcohol abuse? ☐ Yes ☐ No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Are you now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____
- List any medications you are currently taking: _____

_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐Another patient, friend ☐Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Internet ☐ School ☐ Insurance ☐ Other _____

Name of person or office referring you to our practice: _____

Dental Information

- Have you ever had any complications following dental treatment? ☐ Yes ☐ No

  If yes, please explain: _____

- When was your last dental cleaning? _____
- Are you experiencing any dental pain? ☐ Yes ☐ No

  If yes, please explain: _____

- Are you happy with your smile? ☐ Yes ☐ No

  If no, please explain? _____

- What would you like to change about your smile? _____
- Are you interested in whitening your smile? ☐ Yes ☐ No
- Are you interested in orthodontics (braces)? ☐ Yes ☐ No
- Are you interested in replacing missing teeth? ☐ Yes ☐ No
- Are you aware of clenching or grinding your teeth? ☐ Yes ☐ No

Responsible Party or Parent/Guardian Information

The following is for: ☐ the patient ☐ the patient's spouse ☐ parent/guardian

Name: _____ Relationship to patient_____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext: _____ (Cell):_____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ the patient ☐ the parent/ guardian

Employer Name: _____ Phone #_____

Address: _____
Street City, State Zip Code

Insurance Information

Primary Insurance

Name of Policy Holder: _____
Last First MI

Policy Holder's Birth Date:____/____/____ Member Id#: _____ Social Security #_____

Name of Insurance _____

Insurance Company's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Release of Medical/Dental/Payment Information

Please list below any persons who wish us to be able to share your medical, dental or payment information with. If the patient is a minor, it is assumed we will share information with the parent, legal guardian or party responsible for minor.

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient