Campbell Dental Care and Aesthetics

PATIENT INFORMATION

Patient's Last Name _____First Name_____ Age ____ Date of Birth _____ Soc. Sec. No. _____

If Child, Name of Parent _____

If Full-time Student, Name of School _____ Year in School _____

Home Address _____ City _____ Zip _____

Home Phone _____ Cell Phone _____ Email _____

Patient (or Parent) Employed by _____ How long? _____ Bus. Phone _____

Spouse Employed by _____ How long? _____ Bus. Phone _____

Your Children's Names and Ages _____

In Case of Emergency, Name of Nearest Relative Not Living With You _____ Relationship _____

Complete Address _____ Phone _____

Name of Person Who Will Be Responsible for This Account _____

Who Referred You to Our Office? _____

INSURANCE ONLY

Name of Insurance Plan _____ Group No. _____

Name of Policyholder/Employee _____ Soc. Sec. No. _____

Is There a Deductible? _____ Amount of Deductible _____ How Much Has Been Paid? _____

If Dual Coverage, Name of Other Dental Plan _____ Group No. _____

Name of Policyholder/Employee _____ Soc. Sec. No. _____

MEDICAL HISTORY

Physician's Name _____ Address _____

Are You in Good Health? _____ If No, Explain _____

Are You Now, or Have you Been Under a Physician's Care During The Past Two Years? _____

Have You Been Hospitalized or Had a Serious Illness in the Past Five Years? _____

Are You Taking Any Drugs or Medicines Now? _____ If So, Give Names and Purpose_____

_____

Are You Allergic to Penicillin or Any Other Drugs? _____

Women: Are You Pregnant? _____ If So, How Long? _____

Check Any of the Following You Have, Now, or Have Ever Had:

- ☐ **Rheumatic Fever**
- ☐ **Congenital Heart Lesions**
- ☐ **Heart Murmur**
- ☐ **Heart Disease**
- ☐ **Stroke**
- ☐ **High Blood Pressure**
- ☐ **Abnormal Bleeding**
- ☐ **Blood Disease or Anemia**
- ☐ **Epilepsy**
- ☐ **Thyroid Condition**
- ☐ **Diabetes**
- ☐ **Tuberculosis**
- ☐ **Emphysema**
- ☐ **Sinus Trouble, Asthma**
- ☐ **Tumors or Growths**
- ☐ **Liver Disease or Hepatitis**
- ☐ **Kidney Disease or Jaundice**
- ☐ **Stomach, Intestinal Disorders**
- ☐ **Venereal Disease**
- ☐ **Fainting, Nervousness**

DENTAL HISTORY

How Long Since Your Last Dental Visit? _____ What Was Done Then? _____

Name of Previous Dentist _____ City _____

Purpose of This Visit: Check Up? _____ Other Dental Problem (Describe) _____

Have You Ever Had Unusual Difficulties or Complications During or After Dental Treatment? _____

Check Any of the Following You Have Now, or Have Ever Had:

- ☐ **Bleeding Gums Extreme Sensitivity**
- ☐ **Food Collects Between Teeth**
- ☐ **Painful Jaw Joint**
- ☐ **Loose Teeth**
- ☐ **Extreme Sensitivity**
- ☐ **Grinding, Clenching Habit**
- ☐ **Long lasting Mouth Sores**
- ☐ **Complicated Extractions**
- ☐ **Orthodontic (Straightening) Treatment**
- ☐ **Periodontal (Gum) Treatment**
- ☐ **Endodontic (Root Canal) Treatment**
- ☐ **Crown (Cap) or Bridge Treatment**
- ☐ **Denture Treatment**

Is There Anything Else the Doctor Should Know Before Beginning Dental Treatment? _____

I hereby give consent for necessary dental treatment _____Date_____