



Campbell and Schmidt
Cosmetic and Family Dentistry

Patient Information

Patient Name: _____ Preferred Name: _____

Phone: (Home) _____ Email Address: _____

Phone: (Work) _____ Male _____ Female _____ Married _____ Single _____

Cell Phone: _____ Birth Date: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Occupation: _____ Employer: _____

Spouse: _____ Family members : _____

Person responsible for payment of this account: _____

Who may we thank for referring you to our office: _____

Health Information

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

- | | | | |
|-------------|--------------------------|------------------|----------------|
| AIDS/HIV | High/Low Blood Pressure | Heart Disease | Sinus Troubles |
| Anemia | Joint Replacement | Heart Murmur | Epilepsy |
| Asthma | Cancer/Tumor | Pacemaker | Arthritis |
| Diabetes | Rheumatic Fever | Recent Surgery | Tuberculosis |
| Hepatitis | Radiation Treatment | Allergy to Latex | Transplant |
| HPV | Allergy to Nickel/metals | Kidney Trouble | Do you snore? |
| Gerd/Reflux | Contact Lenses | Blood Disorder | CPAP |

Have you ever had a sleep study? Yes No

Do you have any disease, condition, or problem not listed? _____

Are you allergic to: Penicillin Codeine Local Injected Anesthetics Other _____

Have you ever had any complications or allergic reactions following dental treatment? Yes No
If yes, please explain: _____

Women: Are you Pregnant? Yes No

Are you taking Birth Control medication? Yes No

General Health: Excellent Good Fair Date of last physical : _____

Name of your primary Physician: _____ Phone: _____
(Are you in the care of a Specialist? Yes No)

Please list all medications: _____

(Include any dietary supplements)

Are you or have you ever taken any medication for osteoporosis? Yes No

Have you been hospitalized or under the care of a medical doctor during the past 3 years? _____

Has a doctor told you that you need antibiotics to pre-medicate for dental work? _____

Dental Health

Reason for visit: _____

Date of last dental visit _____ Last x-rays taken _____

Will you share why you left your previous dentist? _____

How often do you brush? _____ Floss? _____

What type of brush do you use? Soft Medium Hard Nylon Natural Electric

Do your gums bleed while brushing or flossing? Yes No

Are your teeth sensitive to: Hot Cold Sweets Chewing

Do you or have you ever had the following: Jaw pain Frequent Headaches Jaw Noises

Wear a retainer Loose/Broken fillings Grinding or clenching Wear Night Guard

Do you drink soda pop / sports drinks? Yes No # Times/Day _____

Please list any current or prior tobacco products? _____

Do you gag easily? _____

How do you feel about the appearance of your teeth? _____

Please add anything you feel is important: _____

To the best of my knowledge all the above are correct. If I ever have any changes in my health, or in my medications, I will inform the Doctor at the next appointment

Consent for Services

We consider it a great privilege to have you as a patient in our practice. We will always strive to provide you with the friendliest, highest quality dental care possible. As our pledge to you we will always provide you with a written treatment plan to include the fees of any proposed treatment. Therefore, when you decide to have treatment completed you will understand your financial obligation and payment in full will be required at the time services are rendered.

If you have dental insurance, we will help you receive your maximum allowable benefits. We will provide a super bill form that you can staple to your completed insurance claim form for submission to your dental insurance company. We emphasize that as dental care providers, our relationship is with you, not your insurance company. Whenever necessary we will be happy to correspond with your insurance company to help you receive the maximum benefits.

Returned checks and balances older than 30 days will be subject to additional rebilling fees and collection fees.

Signature of patient, parent or guardian

Date: _____

Relationship to patient: _____

