



Andy Nelson, DDS  
Roger L. Campbell, DDS

Date: \_\_\_\_\_

### Patient Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Mr | Dr | Mrs | Miss | Ms  
Mailing Address: (Street, City, State, Zip) \_\_\_\_\_  
Birthday: \_\_\_\_\_  Male  Female  Single  Married  Widowed  Divorced  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Do you want Email reminders?  Yes  No  
Social Security Number: \_\_\_\_\_ Drivers License Number: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_  
Employer Address: (Street, City, State, Zip) \_\_\_\_\_  
**In Case of Emergency Contact**  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Whom can we thank for referring you to us? \_\_\_\_\_

### Account Information

Person responsible for this account is the same as above  
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Mr | Dr | Mrs | Miss | Ms  
Mailing Address: (Street, City, State, Zip) \_\_\_\_\_  
Birthday: \_\_\_\_\_  Male  Female  Single  Married  Widowed  Divorced  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Do you want Email reminders?  Yes  No  
Social Security Number: \_\_\_\_\_ Drivers License Number: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_  
Employer Address: (Street, City, State, Zip) \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
 Additional Insurance  
Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Mr | Dr | Mrs | Miss | Ms  
Mailing Address: (Street, City, State, Zip) \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
Email Address: \_\_\_\_\_ Do you want Email reminders?  Yes  No  
Social Security Number: \_\_\_\_\_ Drivers License Number: \_\_\_\_\_  
Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_ Employer Phone: \_\_\_\_\_  
Employer Address: (Street, City, State, Zip) \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

### Agreement & Consent

I do authorize and give consent to my Dentist and his/her Dental Team to administer treatment, including, but not limited to local anesthesia, analgesia, and other such treatment which may be necessary for the above named patient.

I understand that I am responsible for all costs of dental treatment. I authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I authorize the dentist to release all information necessary to secure payment of benefits.

Patient or Responsible Party Signature: **X** \_\_\_\_\_ Date: \_\_\_\_\_



Date: \_\_\_\_\_

## Medical History

Although our Dental Team primarily treats areas in and around your mouth, the health of your entire body can influence treatment you may receive. Certain health conditions or medication can have significant interactions with the dentistry you may receive. Please answer the following questions as accurately as possible. Thank You!

- Are you under a physician's care now?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever been hospitalized or had a major operation?  Yes  No If yes, please explain: \_\_\_\_\_
- Have you ever had a serious head or neck injury?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you take, or have you taken, Phen-Fen or Redux?  Yes  No If yes, please explain: \_\_\_\_\_
- Are you on a special diet?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you use tobacco?  Yes  No If yes, please explain: \_\_\_\_\_
- Do you use controlled substances?  Yes  No If yes, please explain: \_\_\_\_\_
- Please list any medications, pills, or drugs you are taking: \_\_\_\_\_

Women: Are you pregnant or trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No

Are you allergic to any of the following?  Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics  
 Other If yes, please explain: \_\_\_\_\_

Do you have, or have you had, any of the following?

- |  |  |  |  |  |
|--|--|--|--|--|
| <input type="checkbox"/> AIDS/HIV Positive         | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Renal Dialysis      | <input type="checkbox"/> Other Serious Illness |
| <input type="checkbox"/> Alzheimer's Disease       | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Hepatitis A, B, or C  | <input type="checkbox"/> Rheumatic Fever     | Please Explain: _____                          |
| <input type="checkbox"/> Anaphylaxis               | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Headaches             | <input type="checkbox"/> Rheumatism          | _____  |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Scarlet Fever       | _____  |
| <input type="checkbox"/> Angina                    | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Shingles            | _____  |
| <input type="checkbox"/> Arthritis/Gout            | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Sickle Cell Disease | _____  |
| <input type="checkbox"/> Artificial Heart Valve    | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Sinus Trouble       | _____  |
| <input type="checkbox"/> Artificial Joint          | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Irregular Heartbeat   | <input type="checkbox"/> Spina Bifida        | _____  |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Stomach Disease     | _____  |
| <input type="checkbox"/> Blood Disease             | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Intestinal Disease  | _____  |
| <input type="checkbox"/> Blood Transfusion         | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Stroke              | _____  |
| <input type="checkbox"/> Breathing Problems        | <input type="checkbox"/> Frequent Headaches        | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Swelling of Limbs   | _____  |
| <input type="checkbox"/> Bruise Easily             | <input type="checkbox"/> Genital Herpes            | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Thyroid Disease     | _____  |
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Mitral Valve Problems | <input type="checkbox"/> Tonsillitis         | _____  |
| <input type="checkbox"/> Chemotherapy              | <input type="checkbox"/> Hay Fever                 | <input type="checkbox"/> Pain in Jaw Joints    | <input type="checkbox"/> Tuberculosis        | _____  |
| <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Heart Attack/Failure      | <input type="checkbox"/> Parathyroid Disease   | <input type="checkbox"/> Tumors or Growths   | _____  |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Ulcers              | _____  |
| <input type="checkbox"/> Congenital Heart Disease  | <input type="checkbox"/> Heart Pace Maker          | <input type="checkbox"/> Radiation Treatments  | <input type="checkbox"/> Venereal Disease    | _____  |
| <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Heart Trouble/Disease     | <input type="checkbox"/> Recent Weight Loss    | <input type="checkbox"/> Yellow Jaundice     | _____  |

## Signature

I certify that the above information is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my (or my patient's) health. I will not hold my Dentist or any members of his/her Dental Team responsible for errors or omissions that I have made in completion of this form. It is my responsibility to notify my Dentist of any changes in the above medical status.

Patient or Responsible Party Signature: **X** \_\_\_\_\_ Date: \_\_\_\_\_