Campbell Dental Group
Gentle Dental Care for the Whole Family

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Today's Date:

PATIENT NAME: _____ DATE OF BIRTH: _____/_____/_____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

HOME#: _____ **WORK#:** _____ **CELL#:**_____

SEX: M F **MARITAL STATUS:** S M D W **SS#:** _____

EMPLOYER/SCHOOL: _____ **OCCUPATION:**_____

May we contact you by Email? Y or N **Email:** _____

PERSON RESPONSIBLE FOR ACCOUNT: *(Please present insurance card)*

NAME: _____ **RELATIONSHIP TO YOU:** _____

ADDRESS: _____ **HOME#:** _____

DATE OF BIRTH: _____/_____/_____ **SS#:** _____-_____-_____ **CELL#:** _____

EMPLOYER: _____ **OCCUPATION:** _____ **WORK#:** _____

MEDICAL HISTORY:

FAMILY DOCTOR: _____ **PHONE:** _____

SPECIALISTS: _____

1.) **ARE YOU ALLERGIC TO:** **LATEX?** Y OR N **PENICILLIN?** Y OR N **MILK?** Y OR N
OTHER DRUG ALLERGIES: _____
OTHER KNOWN ALLERGIES: _____

2.) **ARE YOU CURRENTLY UNDERGOING ANY MEDICAL TREATMENT?** Y OR N ***IF YES- PLEASE EXPLAIN***:
_____
_____

3.) **PLEASE LIST ANY MEDICATIONS YOU ARE CURRENTLY TAKING AND REASON WHY:** **(*Please provide copy if necessary)***
_____

4.) **DO YOU SMOKE OR USE CHEWING TOBACCO?** Y OR N *FREQUENCY AND LENGTH OF USE:* _____

5.) **IF FEMALE, ARE YOU OR COULD YOU BE PREGNANT?** Y OR N …. *DUE DATE*: _____
ARE YOU TAKING BIRTH CONTROL PILLS? Y OR N

6.) **ARE YOU OR HAVE YOU TAKEN BISPHOSPHONATES FOR OSTEOPOROSIS OR BONE CANCER?** Y OR N
IF YES PLEASE LIST_____

** **CHECK ANY CHRONIC CONDITIONS THAT NOW OR HAVE EVER APPLIED TO YOU:**

___ Diabetes	___ Anxiety	___ Depression	___ Thyroid
___ AIDS/HIV	___ Epilepsy	___ Kidney Disease	___ High/Low blood pressure
___ Allergies (Seasonal)	___ Prolonged bleeding	___ Alcohol/Drug dependency	___ Radiation (Head/Neck)
___ Artificial Heart Valve	___ Bruise Easily	___ Mental Illness	___ Blood transfusion
___ Anemia	___ Hepatitis	___ Ulcers	___ Chemotherapy
___ Arthritis	___ Herpes Virus	___ Osteoporosis	___ Heart murmur
___ Asthma	___ Pacemaker	___ Stroke	___ HPV (Human Papilloma Virus)
___ Cancer	___ Heart Conditions	___ Tuberculosis	___ Mitral valve prolapse
___ Emphysema	___ Respiratory problems	___ Venereal Disease	___ Rheumatic fever
___ OTHER: _____		___ Alzheimer's / Dementia	___ Joint Replacement

****I certify to the best of my knowledge the information that I have given is correct.**

SIGNATURE: _____ **DATE:** _____