SCOTT A. CAMPBELL DDS SMILE

Patient Information (CONFIDENTIAL)

Last Name_____ First Name_____ M.I.____

Address_____ City_____ State/Zip_____

Date of Birth_____ Soc. Sec. #_____

Cell phone_____ Home phone_____ E-mail_____

☐ Male ☐ Female Occupation_____

Patient Employer/School_____ Parent/Guardian(if minor)_____

Whom may we thank for referring you?_____

Please check appropriate box:

☐ Minor ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Primary **Dental** Insurance

Full name of person responsible for account_____

Relation to patient_____ Birth date_____ Soc. Sec. #_____

Address (if different from patient's)_____ City_____

State/Zip_____ Cell phone_____ Insured Employer_____

Insurance Company_____ Subscriber #_____

Additional **Dental** Insurance

Subscriber name_____ Cell phone_____

Birth date_____ Soc. Sec. #_____ Relation to patient_____

Address (if different from patient's)_____ City_____

State/Zip_____ Subscriber employed by_____

Insurance Company_____ Subscriber #_____

Dental History

Reason for today's visit_____ Former Dentist_____

Date of last dental care_____ Date of last dental x-rays_____

Please check any of the following:

☐Bad breath ☐Grinding teeth ☐Sensitivity to hot/cold (circle which sensitivity)

☐Sensitivity to sweets ☐Sensitivity to biting ☐Loose teeth/broken fillings

☐Clicking/popping jaw ☐Periodontal treatment ☐ Food collection between teeth

☐ Bleeding gums ☐Sores or growths in your mouth

How often do you brush?_____ How often do you floss?_____

Medical History

Physician's name_____ Date of last visit_____

Have you had any serious illnesses or operations? ☐Yes ☐No If yes, please describe_____

_____

_____

_____.

(Women) are you pregnant? ☐Yes ☐No Nursing? ☐Yes ☐No Taking birth control pills? ☐Yes ☐No

Please check all that apply:

☐Anemia	☐Chemotherapy	☐Heart problems	☐Pacemaker	☐Stroke
☐Arthritis, Rheumatism	☐Circulatory problems	☐Hemophilia	☐Radiation treatment	☐Thyroid problems
☐Artificial heart valves	☐Cough, persistent	☐Hepatitis	☐Respiratory disease	☐Tobacco Habit
☐Artificial joints	☐Diabetes	☐High blood pressure	☐Rheumatic fever	☐Tonsillitis
☐Asthma	☐Epilepsy	☐HIV/AIDS	☐Scarlet fever	☐Tuberculosis
☐Back problems	☐Fainting	☐Jaw pain	☐Shortness of breath	☐Ulcer
☐Blood disease	☐Glaucoma	☐Kidney disease	☐Skin rash	☐Other:_____
☐Cancer	☐Headaches	☐Liver disease	☐Snoring	_____

Medical continued ⟶

Please list all medications, vitamins, and supplements you are currently taking:

Please list all known allergies:

Emergency contact_____ Relation to patient_____

Phone number_____

Authorization

I understand that I am financially responsible for all charges whether or not paid by insurance and that I will pay the amount owed to Scott A. Campbell, DDS at the time of service, unless prior arrangements have been approved.

I authorize my insurance company (if applicable) to pay to the dentist or dental group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize the dentist to release all information necessary to secure the payment of benefits.

I authorize the use or disclosure of my information (this includes verbal release of information and these records may be released electronically) to the individuals listed below

Name(s):_____

Signature_____ Date_____

SCOTT A. CAMPBELL DDS SMILE

Acknowledgement of Receipt of Notice of Privacy Practices

I, (Please Print) _____, have received a copy from Scott A. Campbell, DDS on their Notice of Privacy with regards to protected health information privacy policies. I understand that a copy of this notice is available to me anytime at my request.

I authorize the use or disclosure of my information (this includes verbal release of information and these records may be released electronically) to the individuals listed below

Name(s):_____

_____

_____

Patient signature (or parent/guardian)_____ Date_____

Financial Agreement

In order to control the cost of billing, the patient's portion is due at the time the service is rendered. The undersigned will ultimately be responsible for any bill incurred in this office regardless of insurance. Any account 90 days past due are subject to collection fees. There will be a service charge on all returned checks.

Payment from your insurance is to be paid directly to Dr. Scott Campbell. All benefits quoted are not a guarantee of payment by your insurance company and you understand that final determination can only be made once the claim has been processed.

A $50 fee may be added to your account for each appointment canceled **without** 24 hours notice.

Patient signature (or parent/guardian)_____ Date_____