Welcome to Dr. Campbell, Century Dental

Name: _____ Age _____ Date of Birth ____/____/____
Parent or Guardian _____ Cell Phone # ( )_____
E-Mail _____Social Security # _____
Address (No PO Box)_____ City _____State ____Zip ____
Pt Cell Phone # ( )_____ Home Phone # ( )_____
Drivers License # _____(Please present to front desk)
Employed By _____ Occupation _____Work Phone # ( ) _____
How long have you lived at your address? _____Years ¿Do you Own ☐ or Rent ☐?

What Pharmacy do you use? Name _____ Phone _____ Address _____

Emergency Contacts

Name _____Phone Number ( ) _____Relation _____
Work Address _____City _____State ____Zip _____

Medical and Dental History

Male ❑ Female ❑ Weight _____

I. Reason for Dental Appointment

· Check Up, · Cleaning, · Pain or · Needs?
Explain needs:_____
Date of last Dental Exam? _____
Date of last Dental X-Rays? _____

II. DENTAL HISTORY

1. Yes No Do you brush your teeth at least twice a day?
2. Yes No Do you floss your teeth at least once a day?
3. Yes No Have you seen a dentist recently?
4. Yes No Have you had problems with prior dental treatment?
5. Yes No Are you in pain now? Where? _____

III. Medical Information

Date of last Medical Exam? _____ Temperature ___
Physician _____ Phone # _____

6. Yes No Is your general health good?
7. Yes No Are you being treated by a physician now?
8. Yes No Has there been a change in your health this year?
9. Yes No Are you currently under great personal stress?
10. Yes No Have you been hospitalized or had a serious illness in the last three years? For what? _____

IV. Have You Experienced Recently?

11. Yes No Covid or recent exposure? When _____
12. Yes No Infections or Cancer?
13. Yes No Chest pain (angina)?
14. Yes No Bleeding problems, or bruising easily?
15. Yes No Diarrhea, or nausea?
16. Yes No Vomiting or Seizures?

V. Are You Taking?

17. Yes No Aspirin or blood thinners?
18. Yes No Drugs, medications, over-the-counter medicines? Please List _____

_____

VI. Do You Have Now Or Do You Have History With?

19. Yes No Allergy to Penicillin or Amoxicillin?
20. Yes No Allergies to any other drugs or medications? _____
21. Yes No Allergy to latex
22. Yes No High blood pressure?
23. Yes No Heart disease, or heart attack?
24. Yes No Diabetes?
25. Yes No Hepatitis, other liver disease? What type?_____
26. Yes No Kidney, bladder disease?
27. Yes No Stomach problems or ulcers?
28. Yes No Skin or eye disease?
29. Yes No Drug or alcohol abuse?
30. Yes No Artificial Joint, or Pacemaker?

VII. Women Only

31. Yes No Are you or could you be pregnant?
32. Yes No Are you nursing a baby?
33. Yes No Are you taking birth control pills?

VIII. All Patients

34. Yes No Do you have or have you had any other diseases or medical problems NOT listed on this form? If so, please explain: _____

To the best of my knowledge I have answered every question completely and accurately. I will inform my dentist of any changes in my health and/or medication. I consent for an examination and treatment of my oral conditions including any necessary X-rays. I accept binding arbitration for any subsequent treatment conflicts.

Patient or Guardian's signature _____

Doctor's signature _____ Date _____

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