New Patient Information

Campo Dentistry
Dr James A Campo

Welcome to our practice.
Please take your time to fill out this form completely. The more we learn about you, the better care we are able to provide. We look forward to working with you to maintain a healthy, happy smile.

Patient Information

Patient Number _____

Today's date _____

First name _____ Middle initial _____ Last name _____

I prefer to be called (nickname, etc.) _____ ☐ Male ☐ Female

Address _____ City _____ State _____ ZIP _____

Date of birth _____ Social security no. _____

Home phone (___) ___-____ Work phone (___) ___-____ Cell phone (___) ___-____

Primary contact number (please check one) ☐ Home ☐ Work ☐ Cell Best time to call _____

Fax (___) ___-____ E-mail _____ Driver's license no. _____

Employer _____ Occupation _____

Spouse's name _____ Spouse's employer _____

Whom may we thank for referring you? _____

If the patient is a child

School _____ School phone (___) ___-____ Grade _____

Dental History

Reason for today's visit _____

Are you currently in pain? ☐ Yes ☐ No
If so, please describe: _____

Do you have any dental problems now? ☐ Yes ☐ No
If so, please describe: _____

Have you ever had trouble with a previous dental treatment? ☐ Yes ☐ No
If so, please describe: _____

Level of anxiety about seeing the dentist: (least) 1 2 3 4 5 (most)

Date of last dental exam _____ Date of last cleaning _____ Date of last full mouth X-rays _____

Procedure(s) done at last dental visit _____

Previous dentist's name _____

City _____ State _____ Phone (___) ___-____

Why are you changing dentists? _____

How often do you have dental examinations? _____ How often do you brush your teeth? _____

How often do you floss? _____ What type of bristles do you use? ☐ Hard ☐ Medium ☐ Soft

What other dental aids do you use? (Electric toothbrush, toothpick, etc.) _____

Do you require antibiotics before dental treatment?	☐ Yes	☐ No	Do you have frequent headaches?	☐ Yes	☐ No
Do your gums ever bleed?	☐ Yes	☐ No	Do you clench or grind your teeth?	☐ Yes	☐ No
Have you noticed any mouth odors or bad tastes?	☐ Yes	☐ No	Are your teeth sensitive to heat/cold?	☐ Yes	☐ No
Do you bite your lips or cheeks frequently?	☐ Yes	☐ No	Do you still have your wisdom teeth?	☐ Yes	☐ No

CAMPO DENTISTRY

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Have you ever had:

Periodontal disease/gum treatment	☐ Yes	☐ No	Discomfort in your jaw joint (TMJ/TMD)	☐ Yes	☐ No
Orthodontics treatment	☐ Yes	☐ No	Your teeth ground or bite adjusted	☐ Yes	☐ No
Oral surgery	☐ Yes	☐ No	Serious injury to the mouth or head	☐ Yes	☐ No
A bite plate or mouth guard	☐ Yes	☐ No			

If yes to any of the previous questions, please describe _____

_____

Is there anything else about your past dental treatment(s) that you would like us to know? _____

_____

Medical History

Have you been hospitalized or under the care of a medical doctor during the past 2 years? ☐ Yes ☐ No

If yes, for what? _____

Hospital or Physician's name _____ Phone _____

Hospital or Physician's City _____ State _____

Have you taken any medications or drugs in the past two years? ☐ Yes ☐ No

Are you currently taking any medications or drugs? (including regular doses of aspirin or over-the-counter medicines) ☐ Yes ☐ No

If yes, please explain _____

Have you ever taken Fen-Phen? ☐ Yes ☐ No

If so, how long ago? _____

Have you been to the doctor to check for heart problems? ☐ Yes ☐ No

If so, what are the problems? _____

Do you use tobacco? ☐ Yes ☐ No **Do you use alcohol or any other controlled substance?** ☐ Yes ☐ No

Women only:

Are you pregnant or think you may be pregnant?	☐ Yes	☐ No	Are you nursing?	☐ Yes	☐ No
Are you taking birth control pills?	☐ Yes	☐ No			

Indicate which of the following you have had or have at present:

AIDS/HIV	☐ Yes	☐ No	Difficulty Breathing	☐ Yes	☐ No	Lupus	☐ Yes	☐ No
Alcohol/Drug Abuse	☐ Yes	☐ No	Emphysema	☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No
Allergies or Hives	☐ Yes	☐ No	Epilepsy or Seizures	☐ Yes	☐ No	Nervousness/Anxiety	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Fainting or Dizzy Spells	☐ Yes	☐ No	Neurological Disorders	☐ Yes	☐ No
Arthritis/Rheumatism	☐ Yes	☐ No	Frequent Headaches	☐ Yes	☐ No	Psychiatric/		
Artificial Heart Valve	☐ Yes	☐ No	Glaucoma	☐ Yes	☐ No	Psychological Care	☐ Yes	☐ No
Artificial Bones/Joints	☐ Yes	☐ No	Hay Fever	☐ Yes	☐ No	Radiation Therapy	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Heart (Surgery, Disease,			Rheumatic/Scarlet Fever	☐ Yes	☐ No
Blood Disease	☐ Yes	☐ No	Attack)	☐ Yes	☐ No	Shingles/Chicken Pox	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Heart Pacemaker	☐ Yes	☐ No	Sickle Cell Disease/Traits	☐ Yes	☐ No
Bruise Easily	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Sinus Trouble	☐ Yes	☐ No
Cancer/Chemotherapy	☐ Yes	☐ No	Hemophilia/Abnormal			Snoring/Sleep Apnea	☐ Yes	☐ No
Chest Pain	☐ Yes	☐ No	Bleeding	☐ Yes	☐ No	Stomach Problems/ Ulcers	☐ Yes	☐ No
Cold Sores/Herpes	☐ Yes	☐ No	Hepatitis A B C (circle)	☐ Yes	☐ No	Stroke	☐ Yes	☐ No
Colitis	☐ Yes	☐ No	High or Low Blood Pressure	☐ Yes	☐ No	Swollen Ankles	☐ Yes	☐ No
Contact Lenses	☐ Yes	☐ No	Hospitalized for Any Reason	☐ Yes	☐ No	Thyroid Problems	☐ Yes	☐ No
Cortisone Medicine	☐ Yes	☐ No	Jaundice	☐ Yes	☐ No	Tuberculosis (TB)	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Kidney Trouble	☐ Yes	☐ No	Tumors	☐ Yes	☐ No
Diet (Special/Restricted)	☐ Yes	☐ No	Liver Disease	☐ Yes	☐ No	Venereal Disease/STD	☐ Yes	☐ No

Please list any serious medical condition(s) that you have ever had not listed above:

_____

Are you aware of having an allergic (or adverse) reaction to any of the following:

Aspirin	☐ Yes	☐ No	Iodine	☐ Yes	☐ No	Sedatives	☐ Yes	☐ No
Codeine	☐ Yes	☐ No	Jewelry/Metals	☐ Yes	☐ No	Sulfa Drugs	☐ Yes	☐ No
Anesthetics (i.e. Novocaine)	☐ Yes	☐ No	Latex	☐ Yes	☐ No	Tetracycline	☐ Yes	☐ No
Erythromycin	☐ Yes	☐ No	Penicillin or Other Antibiotics	☐ Yes	☐ No	Other _____		

Patient signature _____

Campo Dentistry
Dr James A Campo

Dental Insurance

Primary Carrier

Insurance co. name _____ Insurance co. phone _____

Address (Street, City, State, ZIP) _____

Group no. (Plan or Policy no.) _____ Insured's I.D. no. _____

Insured's name _____ Relationship to patient _____

Date of birth _____ Insured's social security no. _____

Insured's employer name _____ Is insured a patient in our practice? ☐ Yes ☐ No

Secondary Carrier

Insurance co. name _____ Insurance co. phone _____

Address (Street, City, State, ZIP) _____

Group no. (Plan or Policy no.) _____ Insured's I.D. no. _____

Insured's name _____ Relationship to patient _____

Date of birth _____ Insured's social security no. _____

Insured's employer name _____ Is insured a patient in our practice? ☐ Yes ☐ No

Person Financially Responsible for Account

Name _____ Relationship to patient _____

Social security no. _____ Phone (___) ___-_____

Driver's license no. _____ Date of birth _____

Address (Street, City, State, ZIP) _____

Employer _____ Work phone (___) ___-_____

Preferred payment method: ☐ Cash ☐ Credit Card ☐ Check

Visa/MC/AMEX no. _____ Exp. date _____

If patient is a minor, name of parent or legal guardian and relationship _____

Is this parent or legal guardian currently a patient in our office? ☐ Yes ☐ No

Payment is due in full at the time of treatment

(Unless prior arrangements have been approved)

I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the dental office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge. Should further information be needed, you have my permission to ask the respective healthcare provider or agency that may release such information to you. I will notify the dentist of any changes in my health or medication.

Signature _____ *Date* _____

Person to contact in case of emergency

Name _____ Relationship _____

City _____ State _____ Cell phone _____

Home phone _____ Work phone _____

OFFICE USE ONLY

I VERBALLY REVIEWED THE MEDICAL / DENTAL INFORMATION ABOVE WITH THE PATIENT NAMED HEREIN.

Date _____ Initials _____

Welcome,

Our office screens all new patients for potential air flow disorders prior to any dental treatment. We also screen all existing patients periodically throughout the year. Please complete this form and return it to the front desk staff.

Patient Name: First _____ Last _____ **Gender:** Male Female

Patient Health History: Please check all that apply

	Type 2 diabetes		History of stroke
	Heavy snoring		Difficulty concentrating
	High cholesterol		Heart disease
	Restless sleep		Morning headaches
	Daytime sleepiness		High blood pressure
	Periodically stop breathing during sleep		Headaches/migraines
	COPD		Clench or grind your teeth
	Experience pain (head, jaw, neck, shoulder(s), arm(s), low back)		Been in car accident over 8 mph or any trauma (sports, injury, fall) in the last year

Below are 8 questions regarding sleepiness. Please circle only one answer per question. **Answer these questions as if it is your day off, you've had no stimulants, including caffeine, and you have the opportunity to relax.**

How Likely Are You To Fall Asleep While...	Never	Slight	Moderate	High
1) Sitting and reading?	0	1	2	3
2) Watching TV?	0	1	2	3
3) Sitting inactive in a public place (meeting, theater, etc.)?	0	1	2	3
4) As a passenger in a car for an hour without a break?	0	1	2	3
5) Lying down to rest in the afternoon when circumstances permit?	0	1	2	3
6) Sitting and talking to someone?	0	1	2	3
7) Sitting quietly after lunch without alcohol?	0	1	2	3
8) In a car while stopped for a few minutes in traffic?	0	1	2	3

Score Summary: _____

Patient Information: Please fill out the sections below. Those with asterisks (*) are required.

*Date of birth _____ *Height _____ *Weight _____

*Address _____ *City _____ *State _____ *ZIP _____

SSN # _____ E-mail address _____

Phone numbers: Home _____ Cell _____ *Best #_____

Neck circumference (office can measure if you are unsure) _____

Patient Signature:

_____

Signature (if under 18 years of age, guardian signature needed) Date

James Campo, DDS

Notice of Privacy Practices

I understand that my healthcare concerning my diagnosis, treatment, payment, and insurance will be disclosed when necessary for filling my insurance, and in communicating with other health professionals in the course of my treatment or their office. Limited information will also be disclosed to business supporting the operations of this office such as dental or medical labs, hospitals, accountant, computer support, billing personnel, answering services, and consultants. Disclosure may also occur for any necessary legal purposes or appropriate governmental authorities. If a family member or person is paying for your healthcare with your knowledge, we may disclose information to that family member or person.

I understand that my files are stored on shelves in the business office. Only staff and janitorial personnel may have access to this office during non business hours. I understand that this office will make every effort to keep your information secure and correct any violation of my privacy if this should occur.

I understand that I have the right to access, copy or inspect and correct my healthcare information, the right to resist disclosures and obtain an accounting of disclosures. I have the right to voice my concern about privacy to the practice and/ or secretary of Health and Human Services within 180 days of my discovery of a disclosure violation without fear of retaliatory acts by this office. I may correct my records in the form of a letter signed by me. I also have the right to revoke my authorization for disclosure. (A minimal fee .20/page will be charges to me for copies of records that I request).

I understand that I will receive communication in the form of phone calls and/or postcards to remind me of an existing appointment, or that it is time to schedule an appointment. I may receive mail containing financial information, such as ledgers or bills. Communication may also be sent to me in the forms of fax or e-mails or other electronic means. I understand that if a message is left for me to return a call, the message will contain the doctor's name and phone number. Complete messages concerning my health information may be left on my personal home or work voice mail.

I have read and understand this office policy. I understand that by signing this agreement, I give my permission for the use and disclosure of my personal and health information in order to carry out treatment, payment activities, insurance claims, and health care operations. This offer retains the right to revise the privacy policy.

_____

Signature