



Medical Alert For Office Use

Roy W. Campfield, DMD
Joshua L. Green, DDS
2825 Connery Way
Missoula, MT 59808
(406) 549-5861

Thank you for visiting Discovery Dental Group. We want your visit to be pleasant and comfortable. Please help us by completing this form.

Patient Information

Name LAST FIRST MIDDLE INITIAL NICKNAME

Address STREET

CITY STATE ZIP

Employer Email

Birth date Height Weight

Phone: Home () Social Security #

Work () May we contact you at work? Yes No

Mobile() Male Female

Emergency Contact: Name Phone ()

Insurance

Primary Dental Carrier

Subscriber Name Social Security # DOB

Employer Insurance Co.

Insurance Co. Phone # Group #

Relation to patient

Secondary Dental Carrier

Subscriber Name Social Security # DOB

Employer Insurance Co.

Insurance Co. Phone # Group #

Relation to patient

Insurance Authorization Statement (Sign & Date)

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 and dental treatment. I hereby authorize the Dental Office to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on this page and the medical history is correct to the best of my knowledge.

Signature Date

If Patient is Under 18

Responsible Party Relation to Patient

Address STREET

CITY STATE ZIP

Telephone ()

Other Information

How did you hear about us? _____

What is the reason for today's visit? _____

Is there anything about your smile you would like to change? _____

When was your last dental examination? _____

Why did you leave your last dentist? _____

What did you like most about your last dentist? _____

Medical History and Information

Conditions

Y N

- Abnormal Bleeding
- Alcohol Abuse
- Allergies
- Anemia
- Angina Pectoris
- Arthritis
- Artificial Heart Valve
- Asthma
- Augmentation
- Blood Transfusion
- Blood Thinners
- Cancer
- Chemotherapy
- Colitis
- Congenital Heart Defect
- Diabetes
- Difficulty Breathing
- Drug Abuse
- Emphysema
- Epilepsy
- Facial Surgery
- Fainting Spells
- Fever Blisters
- Frequent Headaches
- Glaucoma
- HIV+ Aids

Y N

- Heart Murmur
- Heart Surgery
- Hemophilia
- Hepatitis A
- Hepatitis B
- Hepatitis C
- High Blood Pressure
- Joint Replacement
- Kidney Problems
- Liver Disease
- Low Blood Pressure
- Mitral Valve Prolapse
- Osteoporosis
- Pace Maker
- Psychiatric Problems
- Radiation Therapy
- Rheumatic Fever
- Seizures
- Sexually Transmitted Disease
- Shingles
- Sickle Cell Disease
- Sinus Problems
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers

Allergies

Y N

- Aspirin
- Codeine
- Dental Anesthetics
- Erythromycin
- Latex
- Metals
- Penicillin
- Sulfa
- Tetracycline
- Food Allergies (i.e., milk, nuts)

Other _____

Y N

- Do you Smoke Or use Tobacco?

If Female

Y N

- Are you taking Birth Control Pills?
- Are you pregnant? If yes, # of weeks _____
- Are you nursing?

Please list all medications

You are currently taking: _____

Treatment Authorization Form

I authorize and give consent to perform dental services agreed between doctor and patient and/or parent or guardian to be necessary or advisable including the use of local anesthesia and other medication as indicated. I certify to the above statements regarding my medical condition.

Payment for all treatment and services rendered are my responsibility and I agree to pay collection and legal fees if any delinquent balance is placed with an agency or attorney for collection or suit.

PATIENTS SIGNATURE

DATE

If patient is a child or requires a guardian:

PARENT/GUARDIAN SIGNATURE

DATE