Charles Campanella, D.D.S.
Rob Low, D.D.S.

7872 La Mesa Boulevard
La Mesa, CA 91942
(619) 464-1211

## Patient Information (Please Print)

Date________________

Thank you for choosing our practice for your dental needs. Please complete this form in ink. If you have any questions or concerns, do not hesitate to ask for assistance. We will be happy to help.

Name ________________ Social Security #________________ Birthdate ________________
First MI Last

Address ________________ City ________________ State ________________ Zip ________________

Home phone #________________ Work phone #________________ Cell phone #________________

E-mail #________________ Drivers License #________________

You or your parent's employer________________ Occupation ________________

Whom may we thank for referring you to us? ________________

## Responsible Party

Person responsible for this account?________________ Date of Birth________________ Drivers Lic #________________

Relationship to patient ________________ Social Security #________________ Phone #________________

Address ________________ City ________________ State ________________ Zip________________

Name of employer ________________ Work phone #________________

## Insurance Information

Name of insured ________________ Relationship to patient ________________

Birthdate ________________ Social Security #________________

Name of employer ________________ Work phone #________________

Insurance Co.________________ Group #________________ ID #________________

Insurance Co Phone # ________________

Do You Have Additional Insurance? ❒ No ❒ Yes If Yes, Please Complete The Following:

Name of insured________________ Relationship to patient ________________ Birthdate________________

Social Security #________________ Name of employer ________________ Work phone #________________

Insurance Co.________________ Group #________________ ID #________________

Insurance Co Phone # ________________

## Terms & Conditions

As a condition of treatment by this office. I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment of all dental services. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

**Assignment of Insurance:** I hereby authorize my insurance company to pay directly to my dentist benefits accruing to me under my policy.

A service charge of 1½% per month(18% per annum)(but in no event more than the maximum rate permissible under state law) will be charged on the unpaid principal balance on all accounts not paid within 60 days of treatment date.

In consideration of the professional services rendered to me by the Doctor and/or his staff, I agree to pay, the reasonable value of said services to said doctor or his assignee, at the time said services are rendered or within (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless objected to by me in writing within the time for payment thereof. Additionally I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree that in the event that either this office or I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceedings shall be entitled to recover all costs incurred including reasonable attorney's and/or collection fees.

If my account is sent to a collection agency a $15 charge will be applied to my account.

I have read the above conditions of treatment and agree to their content:

**A 24 Hour Cancellation Notice is required, to avoid a charge.**

Signed: ________________ Date:________________

# Dental History

Former Dentist ______________________ Phone # __________

Reason for today's visit ______________________

Date of last exam ______________ Date of last dental x-rays ______________

How often do you brush? ______________ How often do you floss? ______________

Please check any of the following conditions that apply to you:

- ❒ Bad breath
- ❒ Bleeding gums
- ❒ Clicking or popping jaw
- ❒ Food collection between teeth
- ❒ Grinding teeth
- ❒ Loose teeth or broken fillings
- ❒ Periodontal treatment
- ❒ Sensitivity to cold / hot
- ❒ Stain / discolored teeth
- ❒ Sensitivity to sweets or biting
- ❒ Sores or growths in your mouth

# Medical History

Physician ______________________ Phone # __________ Date of last visit __________

Please list all medications you are currently taking: ______________________

Allergies: ______________________

Have you used Bisphosphonate drugs used to treat Osteoporosis or bone cancer related issues? __________

Have you taken - Redux, Phen/Phen, Aspirin or Coumadin? ❒ Yes ❒ No Last date taken __________

(Women) Are you pregnant? ❒ Yes ❒ No Nursing? ❒ Yes ❒ No Taking birth control pills? ❒ Yes ❒ No

**Have or have ever had any of the following? Please check (✓) the appropriate box**

| Yes | No | | Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| ❒ | ❒ | Anemia | ❒ | ❒ | Cortisone Treatments | ❒ | ❒ | Hemophilia | ❒ | ❒ | Respiratory Disease |
| ❒ | ❒ | Arthritis, Rheumatism | ❒ | ❒ | Cough, Persistent | ❒ | ❒ | Hepatitis-Type A, B, C | ❒ | ❒ | Rheumatic Fever |
| ❒ | ❒ | Artificial Heart Valves | ❒ | ❒ | Cough up blood | ❒ | ❒ | Herbal Supplements | ❒ | ❒ | Scarlet Fever |
| ❒ | ❒ | Artificial Joints | ❒ | ❒ | Diabetes | ❒ | ❒ | High Blood Pressure | ❒ | ❒ | Shortness of Breath |
| | | Date ______ | ❒ | ❒ | Epilepsy | ❒ | ❒ | HIV Positive | ❒ | ❒ | Skin Rash |
| ❒ | ❒ | Asthma | ❒ | ❒ | Fainting | ❒ | ❒ | Jaw Pain | ❒ | ❒ | Stroke |
| ❒ | ❒ | Back Problems | ❒ | ❒ | Glaucoma | ❒ | ❒ | Kidney Disease | ❒ | ❒ | Swelling of Feet/Ankles |
| ❒ | ❒ | Blood Disease | ❒ | ❒ | Headaches | ❒ | ❒ | Liver Disease | ❒ | ❒ | Thyroid Problems |
| ❒ | ❒ | Cancer | ❒ | ❒ | Heart Murmur | ❒ | ❒ | Mitral Valve Prolapse | ❒ | ❒ | Tobacco Habit |
| ❒ | ❒ | Chemical Dependency | ❒ | ❒ | Heart Problems | ❒ | ❒ | Nervous Problems | ❒ | ❒ | Tonsillitis |
| ❒ | ❒ | Chemotherapy | | | Describe ______ | ❒ | ❒ | Pacemaker | ❒ | ❒ | Tuberculosis |
| ❒ | ❒ | Circulatory Problems | | | ______ | ❒ | ❒ | Psychiatric Care | ❒ | ❒ | Ulcer |
| | | | | | ______ | ❒ | ❒ | Radiation Treatment | ❒ | ❒ | Venereal Disease/STD |

# Authorization

I authorize my insurance company 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 La Mesa Dental Group, dentist(s), and/or dental auxiliary personnel in charge of my care to administer any treatment, anesthetics, and dental procedures necessary in the diagnoses and treatment of my case.

Person to contact in case of emergency ______________________ Phone # __________

__________ Date    ______________________ Signature of Patient, Parent or Guardian    ______________________ Signature of Examining Dentist

| Update | Initial | |
|---|---|---|
| | | |
| | | |
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