

Campos Family Dental P.C.  
Patient History and Health Questionnaire

5250 Blanco Rd  
San Antonio, TX 78216  
(210) 349-3368

5715 Evers Rd  
San Antonio, TX 78238  
(210) 523-6188

4351 Callaghan Rd #1  
San Antonio, TX 78228  
(210) 680-9544

5563 DeZavala Rd Ste.160  
San Antonio, TX 78249  
(210) 696-7885

Name (please print) First: \_\_\_\_\_ Last: \_\_\_\_\_

Prefers to be called \_\_\_\_\_ Please circle One: Child / Single / Married / Divorced / Widow / Widower

Social Security Number \_\_\_\_\_ Driver's License \_\_\_\_\_

Date of Birth: Month: \_\_\_\_\_ Date: \_\_\_\_\_ Year: \_\_\_\_\_ Email Address: \_\_\_\_\_

Home Address: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Tel: ( ) \_\_\_\_\_ Work: ( ) \_\_\_\_\_ Cell: ( ) \_\_\_\_\_ Pager: ( ) \_\_\_\_\_

May we contact you at work? (Please circle one) YES / NO

Employer \_\_\_\_\_ Occupation: \_\_\_\_\_

Method of Payment: Insurance \_\_\_ Medicaid \_\_\_ Cash \_\_\_ Check \_\_\_ Credit Card \_\_\_ Care Credit \_\_\_

**INSURANCE INFORMATION**

Insurance Holder: \_\_\_\_\_ Relation: Self / Parent / Other

Employer: \_\_\_\_\_

Dental Insurance Company: \_\_\_\_\_

Social Security Number \_\_\_\_\_ Date of Birth: Month: \_\_\_\_\_ Date: \_\_\_\_\_ Year: \_\_\_\_\_

Plan/Policy # \_\_\_\_\_ Group # \_\_\_\_\_

**Dental Insurance: To avoid any misunderstanding regarding dental insurance, we would like our patients to know that all professional services rendered are charged directly to the patient. We will file all necessary forms to your insurance company. We do not render our services on the basis that insurance companies will pay our fees. The patient is responsible to any fees the insurance company does not cover.**

**I acknowledge that the dentist(s) and staff are willing to assist me in recovering my dental insurance entitlements. I understand that the dental insurance is a contract between me the insured and the insurance carrier, not between the insurance carrier and the dentist, and that I am responsible for my portion of the payment, including anything the insurance company may not pay.**

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Are you currently experiencing a problem with your teeth, gums or bite? Describe \_\_\_\_\_  
\_\_\_\_\_

When was your last dental check-up? \_\_\_\_\_ Cleaning \_\_\_\_\_ x-rays \_\_\_\_\_

Do you breathe mainly through your nose, mouth or both? \_\_\_\_\_

Do you clench or grind your teeth? *Never Rarely Sometimes Frequently*

How many times a day do you brush? \_\_\_\_\_ How many times a day do you floss? \_\_\_\_\_

Have you ever had any problems, bad experiences or complications with a previous dental treatment? Explain \_\_\_\_\_  
\_\_\_\_\_

Circle the treatment(s) you have had: *braces, biteplates, night guard, root canal, Crown, Implant, surgery for wisdom teeth, gum surgery, bite adjustment, general anesthetic for Surgery, None*

Circle the dental problems you have or have had: *hot/cold sensitive, pressure sensitive, Shifting of teeth, sweet sensitive, food caught between teeth, chipped or broken teeth, None*

Circle the following mouth problems you have or have had: *frequent blisters, Swelling / lumps in mouth, Cheek or lip biting habit, cancers and / or cold sores, None*

Do you play any contact sports? \_\_\_\_\_ Have you ever worn a mouth guard? \_\_\_\_\_

Would you be interested in a personalized sports mouth guard? \_\_\_\_\_

Are you happy with the appearance of your teeth? \_\_\_\_\_

Would you be interested in whitening your teeth? \_\_\_\_\_

Have you ever experienced periodontal disease? \_\_\_\_\_

Have you ever been advised to have your wisdom teeth taken out? \_\_\_\_\_

Please list anything else not mentioned above regarding your past dental history? \_\_\_\_\_  
\_\_\_\_\_

The following information is required for us to assist in proper diagnosis and treatment.

- YES NO Are you in good health?
- YES NO Are you currently, or in the last year, been under the care of a physician? \_\_\_\_\_  
Name of doctor \_\_\_\_\_ Phone # \_\_\_\_\_
- YES NO Has there been any change in your general health in the past year? Please list:  
\_\_\_\_\_
- YES NO Have you ever had a serious illness that required hospitalization or extensive medical care? Please specify: \_\_\_\_\_
- YES NO Are you taking any prescription or non-prescription drugs? Please list them:  
\_\_\_\_\_
- YES NO Have you ever been advised to take antibiotics before a dental appointment?
- YES NO Are you allergic to penicillin, sulfa or any other drugs? \_\_\_\_\_
- YES NO Have you ever been put to sleep for an operation? \_\_\_\_\_
- YES NO Do you have frequent headaches?
- YES NO Do you have difficulty in opening or closing your mouth?

Circle YES or NO if you have or have ever had any of the following?

- |                                      |  |
|--------------------------------------|--|
| Y N Aids                             | Y N Hearing difficulties / Earache               |
| Y N Anemia                           | Y N Hepatitis A / B / C                          |
| Y N Arthritis                        | Y N Heart attack / Rhythm disorder               |
| Y N Asthma                           | Y N Heart disease / Artificial valve             |
| Y N Blood Disorders/Transfusion      | Y N Heart murmur or mitral valve prolapse        |
| Y N Bleeding Abnormally              | Y N Hyper (Hypo) Glycemia                        |
| Y N High blood pressure              | Y N Jaundice                                     |
| Y N Low blood pressure               | Y N Joint replacement / Hip / Knee / Other _____ |
| Y N Bronchitis                       | Y N Venereal diseases / STD's / Herpes           |
| Y N Bulimia                          | Y N Liver disease                                |
| Y N Cancer/ Radiation/ Chemotherapy  | Y N Leukemia                                     |
| Y N Chest pain / Shortness of breath | Y N Lung disease                                 |
| Y N Cardiac pacemaker                | Y N Lupus  |
| Y N Circulation problems             | Y N Malignant hyperthermia                       |
| Y N Cold Sores                       | Y N Psychiatric disorders                        |
| Y N Kidney disease                   | Y N Pregnant _____ Months                        |
| Y N Cortisone / Steroids             | Y N Rheumatic fever / Scarlet fever              |
| Y N Diabetes                         | Y N Skin rash                                    |
| Y N Drug / Alcohol dependency        | Y N Stomach ulcers                               |
| Y N Emphysema                        | Y N Sinus trouble                                |
| Y N Epilepsy / Seizures              | Y N Stroke                                       |
| Y N Gastrointestinal disorders       | Y N Thyroid disease                              |
| Y N Glaucoma                         | Y N Tuberculosis / Coughing blood                |

Are there any conditions not listed above that you presently have or ever had? \_\_\_\_\_  
\_\_\_\_\_

Is there anything else that you would like to discuss with Dr. Campos? \_\_\_\_\_  
\_\_\_\_\_

*I certify this medical history to be accurate to the best of my knowledge.*

Signature \_\_\_\_\_ Date \_\_\_\_\_

How were you referred to our office?

Yellow pages: \_\_\_\_\_ Insurance: \_\_\_\_\_ Medicaid: \_\_\_\_\_ Website: \_\_\_\_\_ Radio: \_\_\_\_\_

Referred by family member: \_\_\_\_\_ Name: \_\_\_\_\_

Referred by friend: \_\_\_\_\_ Name: \_\_\_\_\_

Referred by doctor: \_\_\_\_\_ Name: \_\_\_\_\_

Other: \_\_\_\_\_

**ALL MEDICAL AND DENTAL RECORDS ARE CONFIDENTIAL!**

**Consent to Treatment**

I authorize Dr. Roger S. Campos, and/or his associate(s) \_\_\_\_\_ to perform procedures including, but not limited to, prophylaxis (cleaning), x-rays, administering anesthetics and/or medications, restoring (filling) teeth, removing teeth, endodontic (root canal) therapy, and other procedures he / she may seem necessary for my care.

**Payment Policies**

Payment for professional services must be made at the time services are rendered unless prior arrangements are made. I understand and agree that I am ultimately responsible for the balance on my account. If I fail to meet the requirements you have provided, I know you have no choice but to turn this matter to an outsider for collection as provided by law.

Signature \_\_\_\_\_ Date \_\_\_\_\_