Thank you for selecting our dental team! We will strive to provide you and your family the best possible dental care. Please take a moment to fill out this form completely. If you have any questions, or need assistance, please ask - we will be happy to help!

Patient Information (Confidential)

Name___________________________________ Birthdate ___/___/______
Soc. Sec. # ____________________ Marital Status_______________
Name of spouse________________________ Name of parent (if child) ______________
Address_______________________________________City_____________State ____
Zip ___________ Home phone _________________ Cell phone ________________
E-Mail __________________________________

Patient's Employer ________________________Occupation__________________
Phone __________________

Do you prefer to be called at (please circle) home cell
How did you hear about us? _______________________
An Individual we may thank? ______________________

Responsible Party *(if under 18)*

Name of Responsible Party _____________________ Relation to patient____________
Address___________________________________ Phone _________________
Soc. Sec. #_________________ Birthdate ___/___/______
Employer_________________________

Do you have dental insurance?

Yes____ Please provide us with a copy of your insurance card and sign below
No ____

If insurance is under your spouse, please provide:
DOB___/___/______Employer____

Assignment of benefits

I authorize payment for dental benefits to Dr. Keith E. Campbell for professional services rendered. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered of my behalf. I understand payment and/or patient portion is due on the date of service.

Patient Signature_______________________________ Date: __________________

Consent

The undersigned hereby authorize the doctor to perform all the necessary diagnostic procedures deemed appropriate to make a thorough diagnosis of the patient's dental needs.

Patient Signature_______________________________ Date: __________________