

Confidential Responsible Party Information

Date _____

A B C

Name _____				
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
Residence _____				
_____	_____	_____	_____	_____
Mailing Address _____				
_____	_____	_____	_____	_____
How long at this address? _____ Email address _____				
Previous Address (If less than 3 yrs.) _____				
_____	_____	_____	_____	_____
Home Phone _____ Cell Phone _____ Work Phone _____				
Social Security # _____ DOB _____ Relationship to Patient _____				
Employer _____ Occupation _____ # of years employed _____				
Spouse's Name _____ Relationship to Patient _____				
Employer _____ Occupation _____ # of years employed _____				
Social Security # _____ DOB _____ Work # _____ Cell # _____				

Confidential Patient Information

Patient Name _____ M/F				
_____	_____	_____	_____	_____
Address _____				
_____	_____	_____	_____	_____
Home Phone _____ Age _____ DOB _____ Social Security # _____				
If Patient is a minor, give parent's or guardian's name _____				
If Student, School _____ Grade _____				
List name of any family members treated by Dr. Campbell _____				
Please list some hobbies/interests _____				
Whom may we thank for referring you to our office _____				

Dental Insurance Information

Policy Holder's Name _____ Soc. Sec./ID # _____ DOB _____				
Policy Holder's Employer _____				
Insurance Company _____ Phone # _____ Group # _____				
Do you have dual coverage Yes _____ No _____ if yes:				
Policy Holder's Name _____ Soc. Sec./ID # _____ DOB _____				
Policy Holder's Employer _____				
Insurance Company _____ Phone # _____ Group # _____				
I authorize release of any information relating to this claim. I authorize the payment be made directly to Dr. Steven W. Campbell				
Signature of Policy Holder _____ Signature of Policy Holder _____				

I understand that where appropriate, credit bureau reports may be obtained

Signature (Parent's signature if minor) _____