



CAMP SMILE PEDIATRIC DENTISTRY

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Bring this form with you to your first appointment, or mail to the address at left.

Patient Registration

- 1. Patient's full name Sex Date of birth
2. Child's full address City Zip Telephone
3. Person responsible for this account
Dental insurance address Group or policy number
Name of policyholder Birthdate of policyholder
Additional insurance company Employer
Social Security number: Father Mother
4. Father's name Date of birth
5. Home address Telephone (H)
6. Occupation Employer Telephone (W)
7. Mother's name Date of birth
8. Home address Telephone (H)
9. Occupation Employer Telephone (W)
10. Parent's marital status: Single Married Widowed Separated
11. Is your child adopted? If yes, child's age at adoption
12. Child likes to be called Pets and hobbies
13. School and grade
14. Names and ages of brothers and sisters

Reason for seeking care

How did you hear about our office?

In case of emergency, whom, other than parents, can be notified?
Relationship Telephone

The above statements are true and correct. I hereby authorize the doctors in this office, if they should so choose, to initiate a review of my credit history, realizing that any such information will be treated confidentially. The undersigned hereby authorizes the release of any information relating to all claims for benefits submitted on behalf of myself and/or dependents. I further expressly agree and acknowledge that my signature on this document authorizes my dentist to submit claims for benefits for services rendered without obtaining my signature on each and every claim to be submitted for myself and/or dependents, and that I will be bound by this signature as though the undersigned had personally signed the particular claim. I understand that balances remaining over 90 days from billing will be subject to interest at the rate of 1.5% per month, and agree to pay any and all collection or legal costs incurred should this account be deemed uncollectible.

SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

Dental Information

1. Is this your child's first visit to a dentist? Yes No
2. If not, name of previous dentist _____ How long ago? _____
3. Was dental treatment completed? Yes No Were any of the dental visits unhappy? Yes No
4. What is your primary reason for seeking dental care? _____
5. Has your child complained of any dental problems? _____
6. Has your child had any injuries to the mouth, teeth, or jaw? Yes No Please explain _____

7. Has your child ever had any of the following? If so, please check.
 dental cavities toothaches
 abscesses (gum boils) cold sores (fever blisters)
 stained teeth bad breath
8. Does (or did) your child have habits that might affect oral health?
 clenching or grinding teeth pacifier
 finger or thumb habits mouth breathing
 other
9. Does your child brush daily? Yes No Do you assist? Yes No Is dental floss used? Yes No
10. Do you drink: city water well water bottled water filtered water?
11. How would you describe your child's eating and snacking habits? _____
12. What is your child's attitude toward today's visit? _____
13. Does your child have problems in concentrating learning cooperating understanding?
14. Is there anything else that you think we should know about your child? _____

Because your child is a minor, it is necessary to obtain signed permission from a parent or legal guardian.

The above statements are, to the best of my knowledge, true and correct. I agree to report any health changes to the dentist before any further treatment is performed. I hereby authorize Dr. Raether, associates, and staff to provide any examinations, x-rays, and procedures to diagnose oral and dental disease, and to provide necessary services with the exception of (if none, please so state) _____

I authorize the use of accepted behavior management techniques including nitrous oxide analgesia in order to complete treatment for my child.

I also authorize Dr. Raether and associates to use photographs, x-rays, other materials, and treatment records, without identification of my child, for the purpose of teaching, research, and scientific publications.

This consent shall remain in full force and effect until cancelled.

PATIENT'S NAME

SIGNATURE OF PARENT OR LEGAL GUARDIAN

DATE

No treatment will be initiated until a consultation is completed and the individual responsible for child acknowledges understanding and acceptance of treatment and estimated fees.

Thank you for answering these important questions. They will help us to understand your child and your concerns.

Health Information

Name and address of child's physician _____

Physician's telephone _____

HISTORY

Reviewer's comments:

1. Is your child currently being treated by a physician? Yes No

If yes, why _____

2. Has your child ever been hospitalized? Yes No

If yes, why _____

3. Has your child ever received anesthesia or sedation? Yes No

If yes, when _____

4. Is your child allergic to anything? (medicine, food) Yes No

5. Is your child taking any medicines at this time? Yes No

If yes, what _____

6. Has your child ever had a blood transfusion? Yes No

7. Does your child smoke or use tobacco products? Yes No

ORGANS AND SYSTEMS

Has your child ever had any treatment for any of the following? Please check yes or no:

YES	NO		YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	Blood - Circulatory	<input type="checkbox"/>	<input type="checkbox"/>	Stomach	<input type="checkbox"/>	<input type="checkbox"/>	Muscles
<input type="checkbox"/>	<input type="checkbox"/>	Bones	<input type="checkbox"/>	<input type="checkbox"/>	Kidney - Bladder	<input type="checkbox"/>	<input type="checkbox"/>	Nervous System
<input type="checkbox"/>	<input type="checkbox"/>	Endocrine Glands	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>	Skin
<input type="checkbox"/>	<input type="checkbox"/>	Eyes, Ears, Nose, Throat	<input type="checkbox"/>	<input type="checkbox"/>	Liver	<input type="checkbox"/>	<input type="checkbox"/>	Tonsils, Adenoids

ILLNESS

Has your child ever been diagnosed as having any of the following conditions? Please check yes or no for each:

YES	NO		YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	Pregnancy
<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric Disorder
<input type="checkbox"/>	<input type="checkbox"/>	Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Scoliosis
<input type="checkbox"/>	<input type="checkbox"/>	Autism	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Brain Injury	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis - Type ____	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Problems
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Snoring at Night
<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throats - Frequent
<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Measles	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida
<input type="checkbox"/>	<input type="checkbox"/>	Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>	Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>	Syndrome _____
<input type="checkbox"/>	<input type="checkbox"/>	Cleft Lip/Palate	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Tetanus
<input type="checkbox"/>	<input type="checkbox"/>	Convulsions/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Mouth Breathing	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Nutritional Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Venereal Disease
<input type="checkbox"/>	<input type="checkbox"/>	Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>	Orthopedic Problems	<input type="checkbox"/>	<input type="checkbox"/>	Whooping Cough
<input type="checkbox"/>	<input type="checkbox"/>	Drug or Alcohol Abuse	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Other _____
<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Polio			_____

I certify that I have read and understand the above questions. I will not hold Dr. Raether or any member of his staff responsible for any errors or omissions I may have made in the completion of this form.

SIGNATURE OF PERSON COMPLETING FORM _____ DATE _____

RELATIONSHIP OF PATIENT _____ DATE _____

This is page three of three pages. Please be sure to fill out all three pages.