☐ Ridgeview Medical Bldg
675 Water Street • Suite 2
Excelsior, MN 55331
952 242-9200 phone
952 242-9201 fax

☐ Allina Health Medical Bldg
2805 Campus Drive • Suite 245
Plymouth, MN 55441
763 383-1788 phone
763 383-1768 fax

☐ 212 Medical Center
111 Hundertmark Road • Suite 304N
Chaska, MN 55318
952-361-6759 phone
952-361-6760 fax

1. Patient's full name _____ Sex ____ Date of birth _____
2. Child's address _____ City _____ Zip _____ Home (____)_____
3. Responsible party _____ Email _____
   Cell (____)_____Cell Carrier_____
4. Our office offers the following options for appointment confirmation, please check one: Call____ Text/Email____
   Standard text fees do apply *Cell phone carrier IS required for text confirmation*

   ID Number _____ Group Number _____
   Dental insurance address _____ Birthdate of policyholder _____
   Name of policyholder _____ Employer _____
   Social Security number: Father _____
   Mother_____
5. Parent's name_____ Date of birth _____
6. Home address _____ Telephone (H) _____
7. Occupation _____ Employer _____ Telephone (W) _____
8. Parent's name_____ Date of birth _____
9. Home address _____ Telephone (H) _____
10. Occupation _____ Employer _____ Telephone (W)_____
11. Parent's marital status: ☐ Single ☐ Married ☐ Widowed ☐ Separated
12. Is your child adopted? _____ If yes, child's age at adoption _____
13. Child likes to be called _____ Pets and hobbies _____
14. School and grade _____
15. 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
   - ☐ abscesses
   - ☐ stained teeth
   - ☐ toothaches
   - ☐ cold sores
   - ☐ bad breath
8. Does (or did) your child have habits that might affect oral health?
   - ☐ clenching or grinding teeth
   - ☐ finger or thumb habits
   - ☐ pacifier
   - ☐ 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 CampSmile, 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 CampSmile 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
   If yes, what _____
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	
☐	☐	Blood - Circulatory	☐	☐	Stomach	☐	☐	Muscles
☐	☐	Bones	☐	☐	Kidney - Bladder	☐	☐	Nervous System
☐	☐	Endocrine Glands	☐	☐	Heart	☐	☐	Skin
☐	☐	Eyes, Ears, Nose, Throat	☐	☐	Liver	☐	☐	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	
☐	☐	AIDS/HIV	☐	☐	Epilepsy	☐	☐	Polio
☐	☐	Anemia	☐	☐	Eye Problems	☐	☐	Pregnancy
☐	☐	Allergy	☐	☐	Excessive Bleeding	☐	☐	Psychiatric Disorder
☐	☐	Arthritis	☐	☐	Fainting	☐	☐	Rheumatic Fever
☐	☐	Asthma	☐	☐	Hearing Loss	☐	☐	Scarlet Fever
☐	☐	Autism	☐	☐	Heart Disease	☐	☐	Scoliosis
☐	☐	Brain Injury	☐	☐	Hemophilia	☐	☐	Sickle Cell Anemia
☐	☐	Bronchitis	☐	☐	Hepatitis – Type ___	☐	☐	Sinus Problems
☐	☐	Cancer	☐	☐	Jaundice	☐	☐	Snoring at Night
☐	☐	Cerebral Palsy	☐	☐	Leukemia	☐	☐	Sore Throats – Frequent
☐	☐	Chicken Pox	☐	☐	Measles	☐	☐	Spina Bifida
☐	☐	Cleft Lip/Palate	☐	☐	Intellectual Disability	☐	☐	Syndrome
☐	☐	Convulsions/Seizures	☐	☐	Mumps	☐	☐	Tetanus
☐	☐	Depression	☐	☐	Mouth Breathing	☐	☐	Tuberculosis
☐	☐	Diabetes	☐	☐	Nutritional Deficiency	☐	☐	Venereal Disease
☐	☐	Diphtheria	☐	☐	Orthopedic Problems	☐	☐	Whooping Cough
☐	☐	Drug or Alcohol Abuse	☐	☐	Pneumonia	☐	☐	Other _____

I certify that I have read and understand the above questions. I will not hold CampSmile 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 _____