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

Camp Smile Pediatric Dentistry and Orthodontics Registration Forms

1. Patient's full name: __________________________________ Date of birth: _______ Sex assigned at birth: M ☐ F ☐
2. Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed
3. Address: ____City: ______________________ Zip: ______________
4. Home: _________________________ Cell: ______________________________ Work: ____________________________
5. Email: ____ Social security number: _______________________________
6. Occupation: ____ Employer: _____________________________________
7. Insurance carrier: ____

   Dental insurance address: ____

   Subscriber ID number: ___________________________________ Group number: ______________________________

   Name of policyholder: ______________________________________ Birthdate of policyholder: ___________________

   Employer: ____ Policy holder's social security number: ________________

10. In case of emergency, whom can be notified? ____

    Relationship: ____ Telephone: ______________________________________

11. How did you hear about our practice? (Please specify clinic name, provider name, social media, family/friends, insurance or other)

    ☐ Google ☐ Children are current patients ☐ Social media: __________________ ☐ Other: __________________

    ☐ Insurance: ____________ ☐ Previous dental clinic: _________________ ☐ Family/friends: ________________

The above statements are true and correct. I understand that I am financially responsible for payment on all balances within 30 days of the services rendered. If I do not have dental insurance, I understand I am responsible for paying in full the day services are rendered. I understand that balances remaining 90 days from billing will be subject to interest per each month unpaid and I agree to pay all collections and/or legal fees incurred should this account be deemed uncollectible. I understand that an account deemed uncollectible will be dismissed from the practice.

NAME OF PERSON COMPLETING FORM: ____ DATE: __________

SIGNATURE OF PERSON COMPLETING FORM: ____ DATE: __________

This is page one of three pages. Please be sure to complete all three pages.

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Dental Information

1. Name of referring dentist ____

2. Date of previous visit: ______________________ Were any x-rays taken? ☐ No ☐ Yes

3. Was any dental treatment completed? Please specify: ☐ No ☐ Yes: ____

4. What is your primary reason for seeking orthodontic care? Please specify below.

   ____

   ____

   ____

5. Have you had any injuries to the mouth, teeth, or jaw? ☐ No ☐ Yes

   a Please explain:

   ____

   ____

   ____

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 Camp Smile, associates, and staff to provide any examinations, x-rays, and procedures to diagnose oral and dental disease, and to provide necessary services apart from (if none, please so state): ___________________________________.

I also authorize Camp Smile, associates, and staff to use photographs, x-rays, other materials, and treatment records, without identification, for the purpose of teaching, research, and scientific publications. No treatment will be initiated until a consultation is completed and the individual acknowledges understanding and acceptance of treatment and estimated fees. This consent shall remain in full force and effect until cancelled.

NAME OF PERSON COMPLETEING FORM: ____ DATE: __________

SIGNATURE OF PERSON COMPLETEING FORM: ____ DATE: __________

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Health Information

Name and address of physician: ____
Physician's telephone: ____

HISTORY

		Y	N	
1.	Are you currently being treated by a physician?..	☐	☐	Explain: ______________________
2.	Have you ever been hospitalized?..	☐	☐	Explain: ______________________
3.	Have you ever received anesthesia or sedation?..	☐	☐	Explain: ______________________
4.	Have you ever had a blood transfusion?...	☐	☐	Explain: ______________________
5.	Are you taking any medications?..	☐	☐	Explain: ______________________
6.	Are you allergic to anything (medicines, food, pets, etc.)?..............................	☐	☐	Explain: ______________________
7.	Do you smoke, vape, or use any tobacco products?..	☐	☐	Explain: ______________________

Have you ever been diagnosed or had any treatment of the following conditions? Please check yes or no for each:

Infectious Diseases:	Y	N
HIV/AIDS..	☐	☐
Chicken Pox..	☐	☐
Diphtheria..	☐	☐
Measles..	☐	☐
Mumps...	☐	☐
Pneumonia/Bronchitis.................................	☐	☐
Polio...	☐	☐
Rheumatic Fever...	☐	☐
Scarlet Fever...	☐	☐
Tetanus..	☐	☐
Tuberculosis..	☐	☐
Whooping Cough (Pertussis)........................	☐	☐
Sinus Conditions..	☐	☐
Hepatitis and Type: ____...........................	☐	☐
Other: _________________......................	☐	☐

Congenital Diseases:		
Cleft Lip/Palate..	☐	☐
Heart Disease...	☐	☐
Other: __________________.....................	☐	☐

Blood Disorders/Diseases:		
Anemia...	☐	☐
Sickle-cell...	☐	☐
Excessive Bleeding...	☐	☐
Hemophilia...	☐	☐
Lymphoma..	☐	☐
Leukemia...	☐	☐
Van Willebrand Deficiency............................	☐	☐
Other: __________________.....................	☐	☐

Other:		
Fainting..	☐	☐
Cancer..	☐	☐
Pregnancy...	☐	☐
Transplant History..	☐	☐

Neurobiological/Nervous System Diseases:	Y	N
Cerebral Palsy..	☐	☐
Epilepsy..	☐	☐
Eye Conditions...	☐	☐
Hearing Loss...	☐	☐
Intellectual Disability...	☐	☐
Spina Bifida...	☐	☐
Convulsions/Seizures...	☐	☐
Other:__________________...	☐	☐

Immune System Diseases:		
Allergies...	☐	☐
Asthma..	☐	☐
Diabetes..	☐	☐
Lupus...	☐	☐
Vasculitis..	☐	☐
Psoriasis..	☐	☐
Celiac Disease...	☐	☐
Pernicious Anemia..	☐	☐
Other:_________________...	☐	☐

Bone Diseases:		
Arthritis..	☐	☐
Scoliosis..	☐	☐
Dwarfism...	☐	☐
Osteogenesis imperfecta..	☐	☐
Other: _________________________...........................	☐	☐

Psychiatric Disorders:		
Anxiety...	☐	☐
ADHD/Hyperactivity...	☐	☐
Anorexia..	☐	☐
Bipolar Disorder..	☐	☐
Bulimia..	☐	☐
Depression...	☐	☐
Other: __________________...	☐	☐

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

NAME OF PERSON COMPLETING FORM: ______________________________________ DATE: _________

SIGNATURE OF PERSON COMPLETING FORM: ___________________________________ DATE: _________

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