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
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Camp Smile Pediatric Dentistry and Orthodontics Registration Forms

1. Patient's full name: ____ Preferred name: ______________ Date of birth: ________

2. Sex assigned at birth: ☐ Male ☐ Female

4. Child's address: ____ City/State: __________________ Zip: ___________

5. Responsible party: _____________________________ Phone number: ___________________ Email:____________________________

6. Legal guardian 1 name: ____ Date of birth: _____________

7. Legal guardian 1 address: ____ City/State: ________________ Zip: ____________

8. Legal guardian 1 cell phone: _______________________ Work phone: _________________________ Home phone: ________________

9. Legal guardian 1 occupation: _______________________________ Employer: ____

10. Legal guardian 1 marital status: ____________________________ Social security number: _______________________

11. Legal guardian 2 name: ____ Date of birth: ____________

12. Legal guardian 2 address: ____ City/State: _________________ Zip: ___________

13. Legal guardian 2 cell phone: _____________________ Work phone: ______________________ Home phone: ___________________

14. Legal guardian 2 occupation: ____________________________ Employer: ____

15. Legal guardian 2 marital status: __________________________ Social security number: ______________________

16. Primary dental insurance carrier: _______________________________ Name of policyholder: ________________________________

Subscriber ID number: ________________________ Group number: ___________________ DOB of policyholder: ________________

Employer: ________________________________ Dental insurance address: ____

17. Does the child have any secondary dental insurance through a county or the State of Minnesota? ☐ Yes ☐ No

If yes, please list their PMI (Medicaid ID) number: ____

18. Is your child adopted? ____ Child's age upon adoption: ____________________________

19. In case of emergency, whom, other than parents, can be notified? ____

Relationship: ____ Phone number: ____

20. How did you hear about our clinics? PLEASE SPECIFY.

☐ Social Media (FB, Instagram, etc.) ☐ Google ☐ Pediatrician or other medical provider: _____________________________________

☐ Insurance ☐ Sibling/friends/family/neighbor/co-worker: _______________________________ ☐ Other: _____________________

☐ Previous dentist: ____

21. Names and ages of siblings: ____

22. School and grade: ____

23. Pets and hobbies: ____

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: ___________

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Dental Information

1. Is this your child's first visit to a dentist? ☐ Yes ☐ No

   Name of previous dentist: ____ Date of Visit? ______________

2. Was dental treatment completed? ☐ Yes ☐ No

   Treatment completed: ____

3. Were any of the dental visits unhappy? ☐ Yes ☐ No

   Why? ____

4. Has your child had any injuries to the mouth, teeth, or jaw? ☐ Yes ☐ No

   Please explain: ____

   ____

5. Has your child had an evaluation for, or frenectomy (tongue tie/lip tie) procedure? ☐ Yes ☐ No Date: ____________________

6. What is your primary reason for seeking dental care? ____

7. Does your child brush daily? ☐ Yes ☐ No

8. Do you assist? ☐ Yes ☐ No

9. Is dental floss used? ☐ Yes ☐ No

10. What kind of water does your child 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? ______________________________________

    ____

15. Has your child ever had any of the following? If so, please check.

☐ Dental cavities	☐ Abscesses	☐ Cold sores	☐ Canker sores
☐ Clenching or grinding teeth	☐ Stained teeth	☐ Bad breath	☐ TMJ/TMD conditions
☐ Finger or thumb habits	☐ Toothaches	☐ Mouth breathing	☐ Airway evaluation
☐ Sore throat (frequent)	☐ Snoring	☐ Pacifier use	☐ Other: ____________________

Because your child is a minor, it is necessary to obtain signed permission from a 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 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 authorize Camp Smile, associates, and staff to use photographs, x-rays, other materials, and treatment records, without identification of my child for the purpose of teaching, research, and scientific publications.

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

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 of primary physician and clinic: ____

Physician or Clinic's phone number: ____

HISTORY

1. Is your child currently being treated by a physician, lactation consultant, speech/language pathologist, OT, PT, or chiropractor?
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, why: ____

4. Is your child allergic to anything? (medications, foods, pets, etc.) ☐ Yes ☐ No

If yes, please list: ____

5. Is your child currently taking any medications? ☐ Yes ☐ No

If yes, please list: ____

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

If yes, when: ____

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

If yes, please specify the product(s) used: ____

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

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

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Health Information Continued

ORGANS/SYSTEMS AND ILLNESS

Has your child 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:

- Heart Disease.. ☐ ☐
- Trisomy 21/Down Syndrome....................... ☐ ☐
- Cleft Lip/Palate.. ☐ ☐
- Liver Disease.. ☐ ☐
- MTHFR.. ☐ ☐
- Cystic Fibrosis... ☐ ☐
- Other: __________________.................... ☐ ☐

Blood Disorders/Diseases:

- Anemia.. ☐ ☐
- Sickle-cell.. ☐ ☐
- Excessive Bleeding... ☐ ☐
- Hemophilia.. ☐ ☐
- Leukemia... ☐ ☐
- Van Willebrand Deficiency............................ ☐ ☐
- Other: __________________...................... ☐ ☐

Neurobiological/Nervous System Diseases: Y N

- Cerebral Palsy.. ☐ ☐
- Epilepsy.. ☐ ☐
- Eye Conditions... ☐ ☐
- Hearing Loss.. ☐ ☐
- Intellectual Disability.................................... ☐ ☐
- Spina Bifida... ☐ ☐
- Convulsions/Seizure...................................... ☐ ☐
- Other:__________________....................... ☐ ☐

Immune System Diseases:

- Allergies.. ☐ ☐
- Asthma.. ☐ ☐
- Diabetes... ☐ ☐
- Lupus.. ☐ ☐
- Vasculitis... ☐ ☐
- Psoriasis.. ☐ ☐
- Celiac Disease.. ☐ ☐
- Pernicious Anemia.. ☐ ☐
- Thyroid Disorder_________......................... ☐ ☐

Bone Diseases:

- Arthritis .... ☐ ☐
- Osteogenesis imperfecta .... ☐ ☐
- Scoliosis... ☐ ☐
- Dwarfism.. ☐ ☐
- Other;___________________....................... ☐ ☐

Other:

- Anxiety.. ☐ ☐
- ADHD/Hyperactivity... ☐ ☐
- Anorexia... ☐ ☐
- Autism.. ☐ ☐
- Bipolar Disorder.. ☐ ☐
- Bulimia... ☐ ☐
- Cancer.. ☐ ☐
- Depression... ☐ ☐
- Fainting.. ☐ ☐
- Pregnancy.. ☐ ☐
- Sensory Processing Disorder.......................... ☐ ☐
- Transplant History... ☐ ☐

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SIGNATURE OF PERSON COMPLETING FORM: __________________________________ DATE: _______________