Eric S. Campbell, DDS, MDS, PA

*****PLEASE USE A DARK BLACK PEN TO FILL OUT*****

Or submit online at www.ericcampbellortho.com : New Patients → New Patient Forms

Today's Date: ____/_____/_____

Patient's Name: _____ Male / Female

Birthdate: _____/_____/_____ SSN: _____-_____-_____

School: _____ Grade: _____

Home Address: _____

City: _____ State: ____ Zip Code: _____

Home Phone: _____

Who may we thank for referring you to our office?

If location, marketing, etc, please be specific! ☺

_____

What is your chief orthodontic concern? _____

_____

_____

Email: _____

DENTAL HISTORY

General Dentist: _____ Date of last visit: ____/_____/_____

		Has your child ever complained of:	
Has you child ever been evaluated for orthodontic treatment before?	Y / N		
Have there been any injuries to the face, mouth, teeth, or chin?	Y / N	Jaw joint pain?	Y / N
Have adenoids or tonsils been removed?	Y / N	Popping/Clicking jaw joints?	Y / N
Does your child have any missing or extra permanent teeth?	Y / N	Tightness in jaw joints?	Y / N
Does your child brush his/her teeth adequately?	Y / N	Jaws tired during meals?	Y / N
Does your child floss his/her teeth daily?	Y / N	Frequent headaches?	Y / N

Does any of the following apply to your child?

Clenching/grinding teeth	Y / N	Nursing bottle habits	Y / N	Nail biting	Y / N
Lip sucking/biting	Y / N	Thumb/Finger sucking	Y / N	Speech problems	Y / N
Mouth breather	Y / N	Tongue thrust	Y / N		

MEDICAL HISTORY

Physician: _____ Phone: _____

Please list all medications that your child is currently taking: _____

Please list all medications to which your child is allergic: _____

Has your child ever had any of the following?

Abnormal bleeding	Y / N	Operations/Surgery	Y / N	Heart murmur	Y / N
Drug allergies	Y / N	Cancer	Y / N	Hemophilia	Y / N
Latex allergy	Y / N	Congenital Heart defect	Y / N	HIV+ / AIDS	Y / N
Metal allergy	Y / N	Diabetes	Y / N	Kidney/Liver problems	Y / N
Plastic allergy	Y / N	Handicap/Disability	Y / N	Rheumatic/Scarlet fever	Y / N
Hospital stays	Y / N	Hearing impairment	Y / N	Tuberculosis	Y / N
Mental disability	Y / N	ADD / ADHD	Y / N	Heart Valve Replacement	Y / N

Please explain any serious medical condition your child has ever had: _____

_____

ORTHODONTIC INSURANCE

Primary insurance co. name: _____

Address: _____

_____ Phone: _____

Group #: _____ Policyholder's Name: _____

Birthdate: ____/____/_____ SSN: _____-____-_____

Employer: _____ Relation to patient: _____

ORTHODONTIC INSURANCE

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Secondary insurance co. name: _____

Address: _____

_____ Phone: _____

Group #: _____ Policyholder's Name: _____

Birthdate: ____/____/_____ SSN: _____-____-_____

Employer: _____ Relation to patient: _____

LEGAL GUARDIAN INFORMATION

Name: _____ Relation to patient: _____

SSN: _____-_____-_____ Drivers License #: _____ Birthdate: _____/_____/_____

Current Address: _____ City: _____ State: _____ Zip Code: _____

Previous Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile/Pager #: _____ Work Phone: _____ Ext: _____

Employer: _____ Occupation: _____ How long at current job? _____

Spouse: _____ SSN: _____-____-_____ Drivers License #: _____ Birthdate: _____/_____/_____

Employer: _____ Occupation: _____ How long at current job? _____

Cell Phone: _____Work Phone: _____ Ext: _____

Related patients that are/have been in our care: _____

Names and Ages of other children: _____

Complete this information if different from above

Father's Name: _____

SSN: _____-____-_____ Drivers License #: _____

Birthdate: _____/_____/_____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile/Pager #: _____

Employer: _____ Occupation: _____

Work Phone: _____ Ext: _____

Mother's Name: _____

SSN: _____-____-_____ Drivers License #: _____

Birthdate: _____/_____/_____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Mobile/Pager #: _____

Employer: _____ Occupation: _____

Work Phone: _____ Ext: _____

Complete this section if applicable

Step Mother: _____

Work Phone: _____ Ext: _____

Step Father: _____

Work Phone: _____ Ext: _____

PLEASE READ AND SIGN BELOW

The information that I have provided is correct to the best of my knowledge. I understand that it is my responsibility to inform this practice of any changes in my child's medical status. We are sorry that we cannot accept divorce decrees as assignments of responsibility for a child's orthodontic bills. **I also understand that this practice reserves the right to verify the credit status (obtain a report) of any potential responsible party.**

_____ _____/_____/_____

Signature of Parent/Guardian Date