



Eric S. Campbell, DDS, MDS, PA

*****PLEASE FILL OUT IN DARK BLACK INK*****

Today's Date: ____/____/____

Name: _____ **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?** _____

Work Phone: _____ **Ext:** _____ **Related patients that are/have been in our care:** _____

Names and Ages of any children: _____

<p>Who may we thank for referring you to our office?</p> <p>_____</p>	<p>What is your chief orthodontic concern? _____</p> <p>_____</p>
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DENTAL HISTORY

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

Your current dental health is: Good / Fair / Poor

Have you ever been evaluated for orthodontic treatment before?	Y / N	Have you ever experienced any of the following:
Have there been any injuries to the face, mouth, teeth, or chin?	Y / N	Jaw joint pain? Y / N
Do you have any missing or extra permanent teeth?	Y / N	Popping/Clicking jaw joints? Y / N
Have you ever had a serious problem with any prior dental work?	Y / N	Tightness in jaw joints? Y / N
Do you floss your teeth daily?	Y / N	Jaws tired during meals? Y / N
Do you like your smile?	Y / N	Severe/Frequent headaches? Y / N

MEDICAL HISTORY

Physician: _____ **Phone:** _____

Please list all medications you are taking: _____

Are you allergic to any of the following:

Aspirin Y / N	Dental anesthetics Y / N	Penicillin Y / N
Any metal s/a Nickel Y / N	Erythromycin Y / N	Tetracycline Y / N
Codeine Y / N	Latex Y / N	Any plastics Y / N

Please list any other medications to which you are allergic: _____

Do any of the following apply to you?

Anemia/Radiation treatment Y / N	Drug/Alcohol abuse Y / N	High/Low blood pressure Y / N
Artificial bones/joints Y / N	Emphysema Y / N	HIV+/AIDS Y / N
Artificial valves Y / N	Epilepsy/Seizures Y / N	Hospitalization Y / N
Arthritis Y / N	Fever Blisters/Herpes Y / N	Kidney/Liver problems Y / N
Asthma Y / N	Glaucoma Y / N	Mitral valve prolapse Y / N
Bleeding disorder Y / N	Handicap/Disability Y / N	Psychiatric/Mental problems Y / N
Blood transfusion Y / N	Heart attack/stroke Y / N	Rheumatic/Scarlet fever Y / N
Cancer/Chemotherapy Y / N	Heart murmur Y / N	Shingles Y / N
Congenital heart defect Y / N	Heart surgery/pacemaker Y / N	Sinus problems Y / N
Diabetes Y / N	Hemophilia Y / N	Tuberculosis Y / N
Difficulty breathing Y / N	Hepatitis Y / N	

Please explain any serious medical condition that you have ever had: _____

ORTHODONTIC INSURANCE

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Primary insurance co. name: _____	Secondary insurance co. name: _____
Address: _____	Address: _____
City: _____ State: _____ Zip Code: _____	City: _____ State: _____ Zip Code: _____
Phone: _____ Group #: _____	Phone: _____ Group #: _____
Policyholder's name: _____	Policyholder's name: _____
Birthdate: ____/____/____ SSN: ____/____/____	Birthdate: ____/____/____ SSN: ____/____/____
Employer: _____	Employer: _____
Relation to patient: _____	Relation to patient: _____

Who should we contact in the event of an emergency ?		
Name: _____	Relation: _____	
Home phone: _____	Work phone: _____	Mobile phone: _____

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 medical status. 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