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: _____

Who may we thank for referring you to our office?

_____

What is your chief orthodontic concern? _____

_____

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

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

Primary insurance co. name:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Group #: _____

Policyholder's name: _____

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

Employer: _____

Relation to patient: _____

Secondary insurance co. name:_____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Group #: _____

Policyholder's name: _____

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

Employer: _____

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