



Child Patient Information

Date: _____ Date of Birth: _____ Age: _____ Male/Female

Child's Name: _____
Last First Middle Initial

Address: _____
Street City/State/Zip

Home Phone: _____ Hobbies/Sports: _____

School: _____ Grade: _____

Who may we thank for referring you? _____

Person accompanying patient: _____ Relationship: _____

Do you have legal custody of this child: Yes No

Responsible Party Information

Legal Guardian: _____ Mother Father Grandparent Other _____

Address: _____
Street City State Zip

How long at this address? _____ Home Phone: _____ Work Phone: _____

Previous Address (if less than 3 years): _____
Street City/State/Zip

Employer: _____ City/State: _____ # Years Employed: _____

Social Security #: _____ Date of Birth: _____

Spouses Name: _____

Legal Guardian: _____ Mother Father Grandparent Other _____

Address: _____
Street City State Zip

How long at this address? _____ Home Phone: _____ Work Phone: _____

Previous Address (if less than 3 years): _____
Street City/State/Zip

Employer: _____ City/State: _____ # Years Employed: _____

Social Security #: _____ Date of Birth: _____

Spouses Name: _____

Dental Insurance Information

Subscriber's Name: _____ Subscriber ID #: _____

Insurance Company: _____ Address: _____

Phone #: _____ Group #: _____ Subscribers Employer: _____

Do you have dual coverage? Yes No If yes:

Subscriber's Name: _____ Subscriber ID #: _____

Insurance Company: _____ Address: _____

Phone #: _____ Group #: _____ Subscribers Employer: _____

This office reserves the right to authorize OrthoBanc, LLC, on behalf of Donna J. Stenberg, DDS, MS, obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options.

Please list any brothers/sisters with ages: _____

Medical/Dental History

What is your main concern at this time? _____

General Dentist: _____ Last Visit Date: _____

- Y N Has your child been evaluated or had orthodontic treatment before? Where? _____
Y N Has there been any injury to the mouth, face, teeth or chin? Date: _____
Y N Are you aware of any missing teeth or extra permanent teeth? List: _____
Y N Has your child ever had any noise, pain, stiffness, or difficulty opening in the jaw joint? (TMJ/TMD)?
Y N Does your child brush their teeth daily? Y N Floss their teeth daily?
Does your child generally breathe through their (circle one) Nose Mouth
Y N Does your child have allergies/hay fever? Seasonal Year Round
Y N Have adenoids or tonsils been removed? Date: _____
Y N Is your child in Good Health? Y N Any changes in your child's health in the past year?
Y N Is your child under the care of a physician? For what reason: _____

Physician: _____ Last Visit Date: _____
Name Phone

Specialists seen: _____ Treated For: _____
Name Phone

Y N Any medications (over the counter drugs or prescriptions) currently taken? Please list with their reason.

Please list all drug allergies: _____

Y N Has puberty begun? Females: Y N Has menstruation begun? Date: _____

Has your child ever had any of the following medical problems? Please circle and explain below.

- | | |
|---------------------------------------|--|
| Y N Abnormal bleeding | Y N Hemophilia/Bleeding disorder |
| Y N Allergy to metal/latex | Y N Hepatitis/Jaundice/Liver disease |
| Y N Allergy to plastic | Y N HIV+/AIDS |
| Y N Arthritis | Y N Hospitalized for any reason |
| Y N Asthma | Y N Kidney/Liver problems |
| Y N Cancer/Chemo/Radiation therapy | Y N Need to take antibiotics for dental work |
| Y N Congenital Heart Defect | Y N Rheumatic fever/Scarlet fever |
| Y N Convulsions/Epilepsy/seizures | Y N Severe/Frequent Headaches |
| Y N Diabetes | Y N Sinus Problems |
| Y N Disability/Handicap | Y N Speech problems/Speech therapy |
| Y N Glaucoma | Y N Tuberculosis |
| Y N Hearing Impairment | Y N Venereal Disease |
| Y N Heart Murmur | Y N Any allergic reactions |
| Y N Females: Pregnant/due date: _____ | Y N Implants |

Explain yes responses: _____

Other disease condition or problem not listed here we should know about: _____

I understand that the information regarding my child that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and I understand it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services that my child may need during diagnosis and treatment with my informed consent.

Signature of Legal Guardian

Date