



Patient Information

Date: _____ Male/Female _____

Patient's Name: _____
Last First Middle Initial

Date of Birth: _____ Social Security Number: _____

Address: _____
Street City/State/Zip

Home Phone: _____ Work Phone: _____

Who may we thank for referring you? _____

Responsible Party Information

Name: _____ Single/Married/Divorced/Widowed _____

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: _____

Spouse's Name: _____ Work Phone: _____

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

Social Security #: _____ Date of Birth: _____

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 have 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.

Medical/Dental History

What is your main concern at this time? _____

General Dentist: _____ Last Visit Date: _____

- Y N Have you been evaluated or had orthodontic treatment before? Where? _____
Y N Do you like your smile?
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 Have you ever had any noise, pain, stiffness, or difficulty opening in the jaw joint? (TMJ/TMD)?
Y N Do you brush your teeth daily? Y N Floss your teeth daily?
Do you generally breathe through your (circle one) Nose Mouth
Y N Do you have allergies/hay fever? Seasonal Year Round
Y N Have adenoids or tonsils been removed? Date: _____
Y N Are you in Good Health? Y N Any changes in your health in the past year?
Y N Are you 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: _____

Have you ever had any of the following medical problems? Please circle and explain below.

- | | | | | | |
|---|---|-----------------------------------|---|---|--|
| Y | N | Abnormal bleeding | Y | N | Heart disease/high blood pressure |
| Y | N | Allergy to metal/latex | Y | N | Hemophilia/Bleeding disorder |
| Y | N | Allergy to plastic | Y | N | Hepatitis/Jaundice/Liver disease |
| Y | N | Arthritis | Y | N | HIV+/AIDS |
| Y | N | Asthma | Y | N | Hospitalized for any reason |
| Y | N | Blood transfusion | 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/heart valve, knee, hip |
| Y | N | Currently Nursing | | | |

Explain yes responses: _____

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

I understand that the information 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 medical status. I authorize the dental staff to perform any necessary dental services that I may need during diagnosis and treatment with my informed consent.

Signature

Date