ADULT ORTHODONTIC CONSULTATION

Robert G. Larson, DDS, MSD

6070 North Keystone Avenue
Indianapolis, Indiana 46220
(317) 253-6784

Specialist in Orthodontics

14950 Greyhound Court #1
Carmel, Indiana 46032
(317) 819-678

I. GENERAL INFORMATION

Name ____ Age ____ Birthdate __________ (mm/dd/yr) Sex ____

Address ____ City _________________ State ___ Zip ________

Home Phone _________________ Cell Phone ______________ Email _________________________________

Family Dentist ______________________ Last Visit ___________ Family Physician ______________________

Are you currently being treated by any health practitioner, (i.e. Dentist, M.D., Osteopath, Chiropractor, Physical Therapist)? Yes ☐ No ☐

Explain____

Were your referred to Dr. Larson? Yes ☐ No ☐ If yes, by whom? _______________________________________

II. HISTORY

In your own words, what is the problem? ____

Does anyone else in the family have a similar problem? Yes ☐ No ☐ If Yes, Who? ___________________________

Have other family members been treated in our office? Yes ☐ No ☐ If Yes, Who? ___________________________

Your height? _________ Your weight? _______

Any previous orthodontic care?	Yes	No
Any treatment for disorder of your jaw or muscles?	Yes	No
Any discomfort in your bite?	Yes	No
Any baby or permanent teeth removed by your dentist?	Yes	No
Any major falls or accidents involving the head, face or teeth?	Yes	No
Any difficulty breathing thru nose awake and/or asleep?		
Snoring?	Yes	No
Any habits such as nail biting, lip biting, pipe smoking, gum chewing?	Yes	No
Any speech problems?	Yes	No
Do you have any medical, dental, health or physical condition not described previously?	Yes	No

If Yes, please explain ____

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Do you have any of the following:

Grinding teeth?	Yes	No
Frequent headaches?	Yes	No
Arthritis?	Yes	No
Clicking or popping jaw joints?	Yes	No
Pain in or about ears?	Yes	No
Difficulty opening mouth?	Yes	No
Jaw locking or getting stuck?	Yes	No
Tonsils and adenoids removed?	Yes	No
Rheumatic fever, heart murmur, or other heart problems?	Yes	No
Drug allergy, hay fever, asthma, other allergies?	Yes	No
Diabetes?	Yes	No
Hepatitis?	Yes	No
Psoriasis?	Yes	No
AIDS, ARC or HIV Positive?	Yes	No
Hemophilia?	Yes	No
Frequent cold sores or apthous ulcers?	Yes	No

Your Occupation ___________________________________ Business Phone ____________________________

Place of Employment _______________________________ Social Security Number ______________________

Marital Status ___________ Spouse Name ___________________________ Birthdate ____________________

Policy Holder's Name _______________________________ Social Security Number ______________________

Policy Holder's Employer ____________________________ Name of Insurance Co. ______________________

Insurance ID # ____________________________________ Group # _________________________________

Would you like to receive appointment reminders via email? Yes No

Signature ____ Date ___________________________