ADULT ORTHODONTIC CONSULTATION

ROBERT G. LARSON, DDS, MSD

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Indianapolis, Indiana 46220
(317) 253-6784

Specialist in Orthodontics

14950 Greyhound Court #1
Carmel, Indiana 46032
(317) 819-6784

I. GENERAL INFORMATION

Name _____ Age _____ Birthdate _____ 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 you referred to this office? Yes ❑ No ❑ If yes, by: _____

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 ❑	Do you or have you had any of the following:	
Any treatment for disorder of your jaw joint or muscles?	Yes ❑ No ❑	Grinding teeth?	Yes ❑ No ❑
Any discomfort in your bite?	Yes ❑ No ❑	Frequent headaches?	Yes ❑ No ❑
Any baby or permanent teeth removed by your dentist?	Yes ❑ No ❑	Arthritis?	Yes ❑ No ❑
Any major falls or accidents involving the head, face, or teeth?	Yes ❑ No ❑	Clicking or popping jaw joints?	Yes ❑ No ❑
		Pain in or about ears?	Yes ❑ No ❑
Any difficult breathing thru the nose awake and/or asleep? snoring?	Yes ❑ No ❑	Pain in or about jaw joints?	Yes ❑ No ❑
		Difficulty opening mouth?	Yes ❑ No ❑
Any habits such as nail biting, lip biting, pipe smoking, gum chewing?	Yes ❑ No ❑	Jaw locking or getting stuck?	Yes ❑ No ❑
		Tonsils and adenoids removed?	Yes ❑ No ❑
Any speech problems?	Yes ❑ No ❑	Rheumatic fever, heart murmur, or other heart problems?	Yes ❑ No ❑
Do you have any medical, dental, health or physical condition not described previously?	Yes ❑ No ❑	Drug allergy, hay fever, asthma, or other allergies?	Yes ❑ No ❑
		Diabetes?	Yes ❑ No ❑
Please explain _____		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 _____

Martial Status _____ Spouse's Name/Birth Date _____

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 _____