CHILDREN'S 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) 819-6784

Date _____

Patient's Name _____

Nickname? _____ School _____

Date of Birth _____ Age _____ Sex ___

Patient's Address _____

City/State/Zip _____

Home Phone _____

Child lives with: Both Parents ☐ Mother ☐

Father ☐ Joint Custody ☐ Other _____

Billing Name _____

Address (if different) _____

_____

Email _____ Billing Phone _____

Father's Name _____

Employer _____

Work Phone _____ Cell _____

Father's Birth Date _____ SS# _____

Mother's Name _____

Employer _____

Work Phone _____ Cell _____

Mother's Birth Date _____ SS# _____

Family Dentist _____

Referred by _____

If you have orthodontic insurance, please provide us with the following information:

Policy Holder's Name _____

Name of Insurance Co. _____

Insurance ID # _____ Group # _____

Parent Signature _____

Do you or have you had:	Yes	No
Scoliosis	____	____
Anemia	____	____
Diabetes	____	____
Hepatitis	____	____
Heart Condition	____	____
Rheumatic Fever	____	____
Heart Murmur	____	____
Hemophilia or Other Abnormal Bleeding	____	____
Cracking/Popping Jaw	____	____
Grinding Teeth	____	____
Frequent Earaches	____	____
Frequent Headaches	____	____
Mouth Breathing	____	____
Snoring	____	____
Thumb or Finger Sucking	____	____
Frequent Cold Sores or Apthous Ulcers	____	____
AIDS, ARC or HIV Positive	____	____

List any allergies: _____

_____

In your own words, what is the problem: _____

_____

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

If yes, explain _____

_____

Family Physician _____

Have you had orthodontic treatment before?

Yes ☐ No ☐

If yes, were you treated by a specialist in orthodontics?

Where and by who _____

Do you have any medical, dental, health or physical condition not described previously? Yes ☐ No ☐

If yes, explain _____

_____

Would you like to receive appointment reminders via email: Yes ☐ No ☐