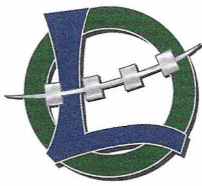

LARSON ORTHODONTICS

Dr. Douglas M. Larson
Dr. James M. Larson
680 Fairmount Ave., W.E.
Jamestown, NY 14701
(716) 483-1718

Welcome to our Practice!

CONFIDENTIAL – PATIENT INFORMATION – CONFIDENTIAL

Please answer all questions and return to our office

PART I – Adult Patient Information

Name:____
(first) (middle) (last)
Address:____
(Post Office Box #'s not accepted as legal residence)
City:____________________ State:____________ Zip Code:__________________
Birthdate: ___/___/_____ Age:____________ Gender: Male Female
Home Phone:____
Cell Phone:____
Email Address:____
Referred By: ____
Physician:____
General Dentist:____ Last Visit?____________

What is your primary concern? Why are you here?______________________________
____
____

PART II – Additional Information

Self:________________________________ Social Security #:__________________
Employer:________________________________ Work Phone:__________________
Orthodontic Insurance? Yes / No Primary or Secondary?:__________________

Spouse:________________________________ Social Security #:__________________
Address (if different from patient):____
Employer:________________________________ Work Phone:__________________
Orthodontic Insurance? Yes / No Primary or Secondary?:__________________

Marital Status: (circle one) Married Seperated Divorced Single

Name of Person(s) financially responsible for this account:__________________________
Relationship to patient:____
Name of Person bringing patient for consultation:__________________________________
Relationship:____
Nearest Relative (not living with you):________________ Phone #:__________________
Has anyone in your family had Orthodontic treatment?______________________________

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PART III – Patient Medical History

	Yes	No
Is patient under medical treatment now?	☐	☐
If yes, for what condition?____		
Has patient ever been hospitalized for any surgical operation or serious injury?	☐	☐
If yes, for what condition?____		
Is patient taking any medications, including non-prescription medicines?	☐	☐
If yes, please list:____		
Is patient allergic to any drugs?	☐	☐
If yes, please list:____		

Does patient have any of the following?

	Yes	No		Yes	No
High Blood Pressure?	☐	☐	Heart Murmur?	☐	☐
Rheumatic Fever?	☐	☐	Fainting / Dizziness?	☐	☐
Seizures / Convulsions?	☐	☐	Neurological Problems?	☐	☐
Heart Disease?	☐	☐	Low Blood Pressure?	☐	☐
Asthma?	☐	☐	Respiratory Problems?	☐	☐
Diabetes?	☐	☐	Emphysema?	☐	☐
Liver Disease?	☐	☐	Hereditary Problems?	☐	☐
Endocrine Problems?	☐	☐	Thyroid Problems?	☐	☐
Hepatitis / Jaundice?	☐	☐	Allergies?	☐	☐
Tuberculosis?	☐	☐	AIDS or HIV Infection?	☐	☐
Epilepsy?	☐	☐	Birth Defects?	☐	☐
Arthritis?	☐	☐	Headaches / Earaches?	☐	☐

Please list any other problems:____

PART IV – Patient Dental History

	Yes	No
Does patient brush his/her teeth conscientiously?	☐	☐
Did patient have primary (baby) teeth removed that were not loose?	☐	☐
Did patient have permanent teeth removed?	☐	☐
Does patient have supernumerary (extra) teeth?	☐	☐
Does patient have congenitally missing teeth?	☐	☐
Does patient have periodontal "gum problems"?	☐	☐
Has patient ever had periodontal treatment?	☐	☐
Does patient suffer from gum boils, frequent canker sores or cold sores?	☐	☐
Is patient taking any forms of fluoride?	☐	☐
Does patient have a thumb or finger sucking habit?	☐	☐
Does patient have an abnormal swallowing habit (tongue thrusting)?	☐	☐
Does patient have a mouth breathing habit?	☐	☐
Does patient have a history of speech problems?	☐	☐
Does patient grind teeth, clench jaw or have clicking or locking of the jaw?	☐	☐
Does patient suffer with jaw pain or ringing in the ears?	☐	☐
Does patient experience any pain/soreness in the muscles of the face or around ears?	☐	☐
Does patient encounter difficulty in chewing or jaw opening?	☐	☐
Is patient concerned about spaced, crooked or protruding teeth?	☐	☐
Has patient ever had prior Orthodontic examinations or treatment?	☐	☐
Would patient object to wearing Orthodontic appliances should they be needed?	☐	☐

Drs. Douglas and James Larson have my permission to obtain diagnostic materials they deem necessary for orthodontic evaluation. I also authorize them to provide other health care providers with the information regarding my orthodontic care if considered appropriate. I also understand it is my responsibility to keep Dr. Larson's office informed of any change in medical or dental health status along with any changes that may be needed on this form.

____

Patient's Signature **Date**