LARSON
Orthodontic Specialists

Members American Association of Orthodontists
My Life. My Smile. My Orthodontist.™

Dr. Matthew Larson
Dr. Katie Larson
715-514-3333
larsonsmiles.com

Patient Full Name: _____

Preferred Name: _____ ☐ Male ☐ Female Date of Birth: _____

Home Address: _____ City/State/Zip: _____

Preferred Email: _____ Preferred Phone #: _____ ☐ Cell ☐ Home ☐ Work

School: _____ Grade: _____ Sports/Hobbies: _____

Siblings (Name/Age): 1) _____ 2) _____ 3) _____

Have any family members previously been treated at our office: ☐ No ☐ Yes _____

How did you hear about our office? Check all that apply: ☐ Dentist ☐ Friend _____

☐ Web Search ☐ Social Media ☐ Magazine ☐ Other _____

Current Dentist: _____ Date of Last Cleaning (approximate) _____

List any other dental specialists currently treating the patient: _____

Chief Concern: _____ Who is concerned? ☐ Dentist ☐ Patient ☐ Parents

How does your child feel about orthodontic treatment? _____

Any previous orthodontic treatment or consultations? _____

Parent's Information:

Patient Lives with: ☐ Both Parents ☐ Dad ☐ Mom ☐ Other _____

Father/Guardian's Full Name: _____ Date of Birth: _____

Address (if different than patient): _____

Preferred Email: _____ Preferred Phone #: _____ ☐ Cell ☐ Home ☐ Work

Mother/Guardian's Full Name: _____ Date of Birth: _____

Address (if different than patient): _____

Preferred Email: _____ Preferred Phone #: _____ ☐ Cell ☐ Home ☐ Work

Dental Insurance: (Fill out all fields – if you provide a copy of your insurance card, still fill out DOB and SSN)

Primary Policyholder Full Name: _____ Date of Birth: _____

Policyholder SSN: _____ Relationship to Patient: _____

Insurance Company: _____ Group #: _____ ID #: _____

Employer: _____ Claims Address: _____

Secondary Policyholder Full Name: _____ Date of Birth: _____

Policyholder SSN: _____ Relationship to Patient: _____

Insurance Company: _____ Group #: _____ ID #: _____

Employer: _____ Claims Address: _____

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Medical History:

Are you in overall good health? ☐ Yes ☐ No Have you had a physical in the last year? ☐ Yes ☐ No

Are you currently under the care of a physician or specialist? ☐ Yes ☐ No If yes, explain _____

Has the patient's physician recommended pre-medication with antibiotics prior to dental appointments? ☐ Yes ☐ No

Do you have allergies to any of the following (please list any additional severe allergies under "other"):

☐ Latex ☐ Metals or Acrylics ☐ Antibiotics or drugs ☐ Other _____

Is there a family history of any of the following conditions?

☐ Severe arthritis ☐ Severe allergies ☐ Extra or missing teeth ☐ Jaw size imbalance or jaw surgery

If so, please explain: _____

Do you chew or smoke tobacco? ☐ Yes ☐ No Females: Are you currently pregnant? ☐ Yes ☐ No

Do you have a history of any of the following conditions: (Check any appropriate boxes and explain below):

☐ ADD/ ADHD	☐ Birth Defects	☐ Fainting	☐ Liver Disease
☐ Anemia/bleeding disorder	☐ Cancer/Tumors	☐ Frequent Headaches/Migraines	
☐ Arthritis	☐ Diabetes	☐ Heart Disease	☐ Nervous Disorders
☐ Asthma	☐ Endocrine/Thyroid Disease	☐ High Blood Pressure	☐ Prolonged Bleeding
☐ Autism	☐ Epilepsy	☐ Kidney disease	☐ Respiratory Disease

Additional information: _____

Please list all medications currently being taken, including prescription, over-the-counter, supplements, and herbal medications.

Medication: _____ Taken for: _____

Medication: _____ Taken for: _____

Any history of bisphosphonate use? (Zometa, Aredia, Didronel, Fosamax, Actonel, Boniva, Skelid, Didronel) ☐ Yes ☐ No

Dental History:

How often do you brush? _____ Floss? _____

Are you currently experiencing any of the following?

☐ Sensitive teeth/gums	☐ Difficulty chewing	☐ Soreness in jaw muscles	☐ Broken/chipped teeth
☐ Clicking/locking of jaw joint	☐ Frequent canker sores	☐ Food frequently trapped between teeth	

Have you previously experienced any of the following (if so, please explain below)?

☐ Dental trauma ☐ Jaw fractures or cysts ☐ Gum problems (periodontal disease)

Any current habits?

☐ Thumb sucking ☐ Fingernail biting ☐ Grinding/Clenching

If yes to any of the above, please explain: _____

Release and Waiver:

I authorize release of any information regarding my child's orthodontic treatment to my dentist and dental insurance company. I have read the above questions and understand them. I will not hold my orthodontist or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. I will notify my orthodontist of any changes in my child's medical or dental health.

Parent/Guardian Signature: _____ Date: _____

431 E. Clairemont Ave, Suite B
Eau Claire, WI 54701

705 Bay Street
Chippewa Falls, WI 54729