LARKIN ORTHODONTICS

We would like to welcome you to our office. Please take the time to fill out this information sheet to help us with your appointment.

Today's Date _____

Patient Information

Name _____
FIRST MI LAST NICKNAME

Birth date ____/____/_____ Age _____ ☐Male ☐Female SS#_____

Email Address: _____

Address _____City_____Zip code_____

Home Phone (____) _____ Cell Phone (____) _____

Martial Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated

Employer:_____ Employer's Address_____

How long there? _____ Occupation: _____

Other Family members we have seen _____

Who may we thank for referring you? _____

General Dentist _____ Location _____

Spouse Information

Name _____

Birth date ____/____/____ Social Security _____-_____-_____

Employer _____ Job Title _____

Work Phone: _____ Cell Phone: _____

Person Responsible For Account

Name _____Relation _____

Billing Address _____

Home Phone (_____)_____ Cell Phone (_____) _____

Employer _____ Work Phone (_____) _____

In the event of an emergency, who should we contact?

Name _____ Relation _____

Home Phone (_____)_____ Cell Phone (_____) _____

Orthodontic Insurance

Insurance Co. Name _____

Claims Address _____

Phone Number (_____) _____ Group Number _____

Policy Holders Name _____

Birth date _____/_____/_____ Social Security _____-_____-_____

Relation to Patient _____ Employer _____

Dental History

What are the main concerns that you would like Orthodontic Treatment to accomplish?

_____ **YES or NO**

Have you ever been evaluated for Orthodontic Treatment before? _____
Have there been any injuries to the face, mouth, chin, or teeth? _____
List any musical instruments played _____
Have adenoids or tonsils been removed? _____
Have you been advised of any missing or extra permanent teeth? _____
Do you brush your teeth daily? _____
Floss Daily? _____
Do you have any speech problems?_____
Have you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? _____
Have you ever taken Phen –Fen?(Also known as Redux or Pondimin) _____
If yes, when_____
Do you smoke or use tobacco in any form? _____

Medical History

Physician _____

Date of last exam _____ **Phone** _____

Please list all medications/supplements that you are taking:

_____

Please list any drugs that you are allergic to:

_____

DO YOU HAVE AN ALLERGY TO ANY OF THE FOLLOWING?

YES or NO

Latex _____ **Metals/Nickel** _____ **Plastics** _____

Have you ever had any of the following medical problems?

	YES or NO
Abnormal Bleeding	_____
Anemia	_____
ADD/ADHD	_____
Any Hospital Stays?	_____
Any Operations?	_____
Artificial Bones/ Joints/ Valves	_____
Asthma	_____
Blood Transfusion	_____
Cancer/Chemotherapy	_____
Congenital Heart Defect	_____
Convulsions/ Epilepsy	_____
Diabetes	_____
Difficulty Breathing	_____
Drug/Alcohol Abuse	_____
Emphysema	_____
Fever Blisters/Herpes	_____
Glaucoma	_____
Handicaps/ Disabilities	_____
Hearing Impairment	_____
Heart Murmur	_____
Heart Attack/Stroke	_____
Heart Surgery/Pacemaker	_____
High/Low Blood Pressure	_____
Hemophilia	_____
Hepatitis	_____
HIV+/ AIDS	_____
Kidney / Liver Disease	_____
Lupus	_____
Mitral Valve Prolapse	_____
Rheumatic/ Scarlet Fever	_____
Radiation Treatment	_____
Severe/Frequent Headaches	_____
Shingles	_____
Sickle Cell Disease/Traits	_____
Sinus Problems	_____
Ulcers/Colitis	_____

	YES or NO
Tuberculosis	_____
Thyroid disease (hypothyroid, hyperthyroid, Graves disease, thyroiditis, mass, goiter)	_____

For Women:

	YES or No
Are you taking birth control pills?	_____
Are you pregnant? Week#_____	_____
Have you ever been treated for osteoperosis?	_____
Have you ever taken Fosomax, Actonel, Boniva or Reclast?	_____

If yes to any of the above please explain:

_____

_____

I understand that the information that I have given is correct to the best of my knowledge, that it will be my responsibility to inform this office of any changes to my medical history. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment or any unpaid balance by the insurance company.

_____

Signature **Date**