

# WELCOME

to the office of  
**Stephen J. Larson, D.M.D., M.S.D.**  
**Specialist in Orthodontics**  
777 Cuesta Drive, Suite 100  
Mountain View, California 94040  
(650) 969-0672

## ABOUT YOU

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_  
Last First MI Mr Mrs Ms

I prefer to be called: \_\_\_\_\_  Male  Female

Birthdate: \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_ SS#: \_\_\_\_\_

Home Address: \_\_\_\_\_  
Apt / Condo #

\_\_\_\_\_ City State Zip

Single  Married  Divorced  Widowed  Separated

Home#: \_\_\_\_\_ Pager/Other: \_\_\_\_\_

Work #: \_\_\_\_\_ ext \_\_\_\_\_ DL#: \_\_\_\_\_

Employer: \_\_\_\_\_

Employer's Address: \_\_\_\_\_

How long there? \_\_\_\_\_ Occupation: \_\_\_\_\_

When/Where are the best time to reach you? \_\_\_\_\_

Whom may we THANK for referring you? \_\_\_\_\_

Other family members seen by us: \_\_\_\_\_

General Dentist: \_\_\_\_\_

Last Visit Date: \_\_\_\_\_

## YOUR SPOUSE

His/Her name: \_\_\_\_\_

Employer: \_\_\_\_\_

Work#: \_\_\_\_\_ ext \_\_\_\_\_ SS# \_\_\_\_\_

Birthdate: \_\_\_/\_\_\_/\_\_\_

## RESPONSIBLE PARTY

Person Responsible for Account: \_\_\_\_\_

Work#: \_\_\_\_\_ ext \_\_\_\_\_ Home#: \_\_\_\_\_

Billing Address: \_\_\_\_\_

Relationship: \_\_\_\_\_ SS#: \_\_\_\_\_

Employer: \_\_\_\_\_ DL#: \_\_\_\_\_

## ORTHODONTIC INSURANCE

Orthodontic Coverage:  No  Yes **Primary**

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone #: \_\_\_\_\_

Group# (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthday: \_\_\_/\_\_\_/\_\_\_ & SS#: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

Orthodontic Coverage:  No  Yes **Secondary**

Insurance Co. Name: \_\_\_\_\_

Insurance Co. Address: \_\_\_\_\_

Insurance Co. Phone#: \_\_\_\_\_

Group# (Plan, Local or Policy #): \_\_\_\_\_

Insured's Name: \_\_\_\_\_ Relation: \_\_\_\_\_

Insured's Birthday: \_\_\_/\_\_\_/\_\_\_ & SS#: \_\_\_\_\_

Insured's Employer: \_\_\_\_\_

# MEDICAL HISTORY

Do you have a personal physician?  No  Yes

Physician's Name: \_\_\_\_\_

Phone #: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_

Your current physical health is  Good  Fair  Poor

Are you currently under the care of a physician?  No  Yes

Please explain \_\_\_\_\_

Are you taking any prescription / over-the-counter drugs?  No  Yes

Please list each one \_\_\_\_\_

**Have you ever had any of the following disease or medical problems?**

- |                                  |                                  |
|----------------------------------|----------------------------------|
| Y N Heart Attack / Stroke        | Y N Psychiatric Problems         |
| Y N Cancer / Chemotherapy        | Y N Heart Murmur                 |
| Y N Epilepsy/Seizures/Fainting   | Y N Diabetes / Tuberculosis (TB) |
| Y N Rheumatic Fever              | Y N Drug / Alcohol Abuse         |
| Y N HIV+ / AIDS                  | Y N Venereal Disease             |
| Y N Heart Surgery / Pacemaker    | Y N Shingles                     |
| Y N Hemophilia/Abnormal Bleeding | Y N Ulcers / Colitis             |
| Y N Mitral Valve Prolapse        | Y N Congenital Heart Defect      |
| Y N Kidney Problems              | Y N Anemia/Radiation Treatment   |
| Y N Artificial Valves            | Y N Difficulty Breathing         |
| Y N Sinus Problems               | Y N Hospitalized for Any Reason  |
| Y N High / Low Blood Pressure    | Y N Hepatitis                    |
| Y N Fever Blisters               | Y N Blood Transfusion            |
| Y N Server/Frequent Headaches    | Y N Emphysema / Glaucoma         |

Please list any medical condition(s) that you have ever had: \_\_\_\_\_

**Are you allergic to any of the following items?**

- |                  |                  |                        |
|------------------|------------------|------------------------|
| Y N Penicillin   | Y N Tetracycline | Y N Dental Anesthetics |
| Y N Aspirin      | Y N Latex        | Y N Any Metal/Plastic  |
| Y N Erythromycin | Y N Codeine      | Y N Other              |

Please list any other drugs that you are allergic to: \_\_\_\_\_

# DENTAL CONCERNS

**What are the main concerns that you would like orthodontics to accomplish?**

\_\_\_\_\_

\_\_\_\_\_

Have you ever had/been evaluated for orthodontic treatment?  No  Yes

Have you ever had a serious/difficult problem associated with any previous dental work?  No  Yes

**Do you now or have you ever experienced pain or discomfort in your jaw joint (TMJ / TMD)?**  No  Yes

Your current dental health is  Good  Fair  Poor

Do you like your smile?  No  Yes

Do your gums ever bleed?  No  Yes

Have you ever had an injury to your (circle): Mouth Teeth Chin

Do you have any speech problems? \_\_\_\_\_

\_\_\_\_\_

Do you generally breath through your mouth AWAKE?  No  Yes

ASLEEP?  No  Yes

Do you have any missing or extra permanent teeth?  No  Yes

**I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental services with my informed consent that I may need during diagnosis and treatment.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Thank You for filling out this form completely

**This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the**

**discretion of this office, use the services of one or more credit reporting services.**

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA**

**Office Use Only**

I verbally reviewed the medical/dental information above with the patient named herein. Initials \_\_\_\_\_ Date \_\_\_\_\_

Doctor's Comments \_\_\_\_\_

\_\_\_\_\_