1215 Plumas Street, Ste. 500
Yuba City, CA 95991

MICHAEL D. LARSON, D.D.S., M.S.D
Orthodontist

Office (530) 674-5047
Fax (530) 674-9366

Welcome

Patient Information

Patient's Name_____ Nickname_____ Date_____

Patient's Address_____ City_____ State_____ Zip _____

Home Phone _____ Work Phone_____ Cell Phone _____

Patient's Occupation _____ Employer _____

Patient's Age _____ Birthdate _____ SS# _____
(If over 18 years old.)

Patient's Sex: Male Female Height _____ Weight _____

Patient's Marital Status: Single Married Divorced Widow

If Married, Spouses Name _____ Birthdate _____ Employer _____

Referred to us by: _____

If patient is under 18 years old:

Brother's names & ages: _____ / _____ / _____

Sister's names & ages:_____ / _____ / _____

Dental Insurance Info

Primary Insurance Company_____ Cardholder's Name _____

SS#_____ Insurance ID#_____ Date of Birth _____

Primary Insurance Company_____ Cardholder's Name _____

SS#_____ Insurance ID#_____ Date of Birth _____

Parent/Guardian Information

Is patient's mother married to patient's father? Yes ❑ No ❑ **Please Note:** If no, the Parent or Guardian who accompanies the patient, is financially responsible for the account.

Who is financially responsible for the account? _____

Circle One: Mother or Step-Mother Name: _____ Date of Birth: _____

Address: _____ DL# _____

Occupation: _____ Employer _____

Work Phone: _____ Home Phone: _____ Cell Phone: _____ SS# _____

I consent to Michael D. Larson using my cell number to (please check one or both) ❑ Call or ❑ Text regarding appointments, treatment, insurance, and my account.

Cell Provider _____ Initial _____

Circle One: Father or Step-Father Name: _____ Date of Birth: _____

Address: _____ DL# _____

Occupation: _____ Employer _____

Work Phone: _____ Home Phone: _____ Cell Phone: _____ SS# _____

I consent to Michael D. Larson using my cell number to (please check one or both) ❑ Call or ❑ Text regarding appointments, treatment, insurance, and my account.

Cell Provider _____ Initial _____

(Patient information continued on back)

Patient Medical History

Physician's Name _____ Patient's General Health: Poor Good Excellent

List any allergies to medications: _____

List any serious illnesses, diseases, or injuries: _____

List any operations: _____

Has the patient taken any of the group of drugs collectively referred to as "fen-phen"? (including Redux) Yes ❑ No ❑ Reason: _____

_____

Is the patient now under a physician's care? Yes ❑ No ❑ Reason: _____

Is the patient taking any medication or drugs? (Including Birth Control Pills) Yes ❑ No ❑ Reason: _____

Females: Age you started menstruating: _____

Have you had, or do you currently have: Check box Yes or No **(Please DO NOT draw a line through boxes)**

Yes ❑ No ❑ Asthma
Yes ❑ No ❑ Hay Fever
Yes ❑ No ❑ Hives
Yes ❑ No ❑ Heart Murmur
Yes ❑ No ❑ Rheumatic Fever
Yes ❑ No ❑ High Blood Pressure
Yes ❑ No ❑ Low Blood Pressure
Yes ❑ No ❑ Eczema
Yes ❑ No ❑ Diarrhea
Yes ❑ No ❑ Latex Allergy

Yes ❑ No ❑ Cancer
Yes ❑ No ❑ Nausea
Yes ❑ No ❑ Vomiting
Yes ❑ No ❑ Tumors
Yes ❑ No ❑ Excessive Bleeding
Yes ❑ No ❑ Kidney Problems
Yes ❑ No ❑ Bladder Infection
Yes ❑ No ❑ Diabetes
Yes ❑ No ❑ Polio
Yes ❑ No ❑ Osteoporosis

Yes ❑ No ❑ Mono
Yes ❑ No ❑ Hepatitis B
Yes ❑ No ❑ AIDS
Yes ❑ No ❑ Arthritis
Yes ❑ No ❑ Frequent Sore Throat
Yes ❑ No ❑ Hearing Loss
Yes ❑ No ❑ Vision Problems
Yes ❑ No ❑ Speech Problems
Yes ❑ No ❑ Psychiatric Problems
Yes ❑ No ❑ TB

DENTAL HISTORY:

Dentist's name _____

Have you ever or do you currently: Check box Yes or No **(Please DO NOT draw a line through boxes)**

Yes ❑ No ❑ Thumb Sucking
Yes ❑ No ❑ Tongue Thrusting
Yes ❑ No ❑ Mouth Breathing
Yes ❑ No ❑ Tonsils Out
Yes ❑ No ❑ Adenoids Out
Yes ❑ No ❑ Cold Sores
Yes ❑ No ❑ TMJ Problems

Yes ❑ No ❑ Jaw Pops
Yes ❑ No ❑ Jaw Locks
Yes ❑ No ❑ Clinches Teeth
Yes ❑ No ❑ Wisdom Teeth Hurt
Yes ❑ No ❑ Sensitive Teeth
Yes ❑ No ❑ Cavities

Yes ❑ No ❑ Periodontal Disease
Yes ❑ No ❑ Crowded Teeth
Yes ❑ No ❑ Protruding Teeth
Yes ❑ No ❑ Ugly Teeth
Yes ❑ No ❑ Grinds Teeth
Yes ❑ No ❑ Prior Ortho. Work

Will the patient cooperate with orthodontic treatment by keeping regular appointments, brushing their teeth,

and wearing orthodontic appliances? _____

CHIEF COMPLAINT:

Why did you come to the orthodontist? _____

_____

AUTHORIZATION

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the orthodontist to help determine appropriate and healthful orthodontic treatment. If there is any change in my medical status, I will inform the orthodontist.

I authorize the insurance company indicated on this form to pay to the orthodontist all insurance benefits otherwise payable to me for services rendered.
I authorize the use of this signature on all insurance submissions.

I authorize the orthodontist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

The new patient examination is complimentary; however, there could be a charge for any X-ray(s) taken.

Signature _____ Date _____

Relationship to Patient _____

Dental Insurance Information

As a courtesy, we will assist you with your dental insurance but we will need your help. In order to research your benefits or submit a claim, it is necessary for you to complete this form. Make sure it is the dental and **NOT** the medical information.

Use the name of the patient and cardholder that appears on the dental insurance card. Thank you.

Patient's Name: _____ Date of Birth: _____

PRIMARY INSURANCE

Insurance Company's Name: _____ Phone #: _____
Address: _____ City: _____ Zip Code: _____

Cardholder's Name: _____ Phone #: _____
Address: _____ City: _____ Zip Code: _____
Employer: _____

SS #: _____ Insurance I.D. #: _____ Date of Birth: _____
Effective Date: _____ Group #: _____

SECONDARY INSURANCE

Insurance Company's Name: _____ Phone #: _____
Address _____ City: _____ Zip Code _____

Cardholder's Name: _____ Phone #: _____
Address: _____ City: _____ Zip Code: _____
Employer: _____

SS #: _____ Insurance I.D. # _____ Date of Birth: _____
Effective Date: _____ Group #: _____

I authorize the release of any information relating to this claim and authorize payment directly to the below named dentists of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment.

_____ _____
Signed (patient or parent if minor) Date

Michael D. Larson, D.D.S., M.S.D.
1215 Plumas Street Suite #500 Office #: (530) 674-5047 Fax #: (530) 674-9366
Yuba City, Ca 95991

FOR OFFICE USE ONLY

Date: _____ Spoke With: _____ Effective Date: _____

Orthodontic Lifetime Max: _____ Percent of Coverage: _____ Ded: _____ Age Limit: _____

Pre-Auth Required Yes No Waiting Period Yes No

If yes, when can patient start braces: _____

IS RECORDS FEE OUT OF ORTHO or BASIC/PREVENTIVE? _____

Paid: Monthly or Quarterly ----- Auto or Submit

Down payment paid at: _____ Used Ortho: _____

Address to submit claims: _____

Ortho Cap on months for treatment: _____

Your "Smile" Questionnaire

Date:_____

In order to evaluate your needs and expectations as accurately as possible, please help us by answering the following questions:

Do you feel that your teeth are (circle all responses):

Too small or short?	No	Yes
Too large or long?	No	Yes
Crooked or crowded?	No	Yes
Misshaped (uneven/pointed)?	No	Yes
Off Color?	No	Yes

Do you feel your front teeth stick out too much ("Buck Teeth)? No Yes

Are there spaces between your teeth that you do not like? No Yes

Is there too much or too little gum tissue showing when you smile? No Yes

Has there been previous orthodontic treatment (including braces or other appliances)?

No Yes

If so, when and by whom?_____

Is there a specific time of the day or week when you must be seen?_____

Are there other dental issues not listed above that you would like to discuss or have treated?

No Yes (explain)_____

_____

Signature_____Relationship_____

PERMISSION SLIP
For All Social Media
(FACEBOOK)

We would like your permission to use your name and picture(s) on all social media. Your name and picture(s) will only be used by Michael D. Larson, D.D.S., Yuba City Ortho.

_____YES, I grant permission to use name and photo(s).

_____NO, I do not grant permission to use name and photo(s).

NOTE: Even if you have selected NO above this form must be signed by the patient/parent/guardian. Thank You.

Patient Name (PLEASE PRINT):

_____

Relationship to patient:

_____

Signature (if under 18 parent/guardian):

_____

Date: _____