

Welcome to Theroux Orthodontics!

Please fill out this form completely. Thank you!

About You

Today's Date _____

Name _____ Preferred Name/Nickname _____

Street Address _____

City _____ State _____ Zip _____ Home Phone _____

Birth Date ____/____/____ Age _____ Sex M F Employer _____

Day-Time Phone _____ Cell Phone _____ E-mail Address _____ Spouse's Name _____

How did you hear about our office? _____

What is the reason you are seeking an orthodontic evaluation? _____

Has an orthodontist been consulted previously? Yes No Reason: _____

Please list other family members seen in our office and their relation to you: _____

Medical Health Information

Have you been hospitalized for any surgical procedure or serious illness? Yes No

Name of your physician _____

Address _____ Phone _____

Do you have or have you had any of the following diseases or conditions? (Check those that apply.)

- | Yes | No | Yes | No | Yes | No |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Do you now or have you ever taken bisphosphonates, including Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, or Zometa? ____ If so, which drug? _____

Do you have any disease, condition, or problem not listed that you think we should know about? Please explain: _____

Are you taking any medication at this time? Yes No, If yes, please list: _____

Dental Insurance Information

Primary Insurance Company Name _____

Address _____ Group/Plan Number _____

Primary Policy Holder Name _____ Social Security Number ____/____/____ Date of Birth ____/____/____

Secondary Insurance Company Name _____

Address _____ Group/Plan Number _____

Secondary Policy Holder Name _____ Social Security Number ____/____/____ Date of Birth ____/____/____

Do you participate in a flex plan? **Y or N**

Dental Health Information

Are you experiencing any dental problems? Yes No Date of last dental visit ____/____/____

How often do you brush and floss each day? Brush ____ times per day Floss ____ times per day

Dentist _____ Address _____

Phone _____

Do you have or have you had any of the following diseases or problems?

- | Yes | No | Yes | No | Yes | No |
|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
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| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

I acknowledge that the above information is correct. I will notify Theroux Orthodontics of any changes that occur after this date.

I hereby authorize Theroux Orthodontics and its designees to perform an initial orthodontic evaluation/examination.

NAME _____ DATE _____

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