

Welcome to Theroux Orthodontics!

Please fill out this form completely. Thank you!

About Your Child

Today's Date _____

Patient's Name _____ Preferred Name/Nickname _____
Address _____
City _____ State _____ Zip _____ Home Phone _____
Birth Date ____/____/____ Age _____ Sex M F School _____ Grade _____

Parents or Guardians

Patient Lives With: Both Parents Separately Both Parents Together Mother Father Other _____
Father/Guardian _____ Employer _____ Day-Time Phone _____ Cell Phone _____
Mother/Guardian _____ Employer _____ Day-Time Phone _____ Cell Phone _____
Parent Address (if different from patient's) _____ E-Mail Address _____
City _____ State _____ Zip _____

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 relationship to this patient: _____

Medical Health Information

Is patient adopted? Yes No At what age? _____
Name of your child's physician _____
Address _____ Phone _____

Does your child have or has he/she 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"/>
<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"/>
<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"/>
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Does this patient now or has he/she ever taken bisphosphonates, including Fosamax, Didronel, Boniva, Aredia, Actonel, Skelid, or Zometa? ____ If so, which drug? _____ If female, has she begun menstruating? _____
Does your child have any disease, condition, or problem not listed that you think we should know about? Please explain: _____

Is your child 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

Is your child experiencing any dental problems? Yes No Date of last dental visit: ____/____/____
How often does your child brush and floss each day? Brushes ____ times per day Flosses ____ times per day
Child's Dentist _____ Address _____ Phone _____

Does your child have or has he/she 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"/>
<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"/>
<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"/>

Personal Information

Does the patient have any siblings? Yes No If yes, what are their ages? _____
Please list any special interests of the patient (sports, hobbies, etc.). _____
Patient's attitude toward orthodontic treatment: Very Motivated Will Cooperate (if needed) Not Motivated

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 for my child.

NAME _____ DATE _____ (Parent or Guardian) Rev 9/18/07