Health History Form

TOTAL ORTHODONTICS

Kevin L. Theroux, D.D.S., M.S.
Brooks J. Barefoot, D.D.S.

Revised 05/6/2017

Patient Information

Today's Date _____ ☐ Male ☐ Female

Name _____
First MI Last

Preferred Name _____

Date of Birth _____ Age _____

Medical/Dental History

Primary Dentist _____

Primary Care Physician _____

Are you taking any prescription medication? ☐ Yes ☐ No

If so, which ones? _____

Are you currently taking a bisphosphonate for osteoporosis? ☐ Yes ☐ No

List any drug sensitivities _____

Please check all of the following that apply

☐ Asthma ☐ Jaw Joint Pain ☐ Teeth Grinding
☐ Diabetes ☐ Bone Disorders ☐ Heart Condition
☐ Epilepsy ☐ ADD/ADHD ☐ AIDS/HIV
☐ Hepatitis

Have you been informed of any missing/extra teeth? ☐ Yes ☐ No

Has an orthodontist previously been consulted? ☐ Yes ☐ No

Previous orthodontic treatment? ☐ Yes ☐ No

Thumb sucking habit or tongue thrust? ☐ Yes ☐ No

Patient breathes mostly through: Nose Mouth (Circle one please.)

Does patient snore? ☐ Yes ☐ No

History of sleep apnea in family? ☐ Yes ☐ No

Any other medical concerns or conditions?

_____

Child Patients Only

School _____

Is the patient adopted? ☐ Yes ☐ No

Boy: Has his voice changed? ☐ Yes ☐ No

Girl: Has she started menstruation? ☐ Yes ☐ No

If yes, Month/Year _____

Who does he/she live with?

☐ Both Parents Together ☐ Both Parents Separately ☐ Mother ☐ Father ☐ Other

Resp. Party Information

Name _____

Relationship to Patient _____

Employer _____

Occupation _____

Work # _____

☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

Resp. Party Email _____

Spouse/Other _____

Relationship to Patient _____

Employer _____

Occupation _____

Work # _____

Are there any other family members that you would like us to evaluate? ☐ Yes ☐ No _____

Family members previously seen:

_____

Whom may we thank for referring you to our office?

_____

Insurance (if not previously given to us)

Primary Dental Insurance

Group Number _____

Insured's Name _____

Relationship to Patient _____

Insurance Company & Address _____

_____

Date of Birth _____ ID/SS# _____

Secondary Dental Insurance

Group Number _____

Insured's Name _____

Relationship to Patient _____

Insurance Company & Address _____

_____

PLEASE SIGN BELOW

X _____ Signature