AVERY ORTHODONTICS
Blair R. Barnett, DDS, MS

Please review the following information and make any changes necessary. Please fill in any missing information. (Please print)

Date:

Patient Information

Patient Name: _____ Gender: _____
Nickname: _____ Date of Birth: _____
Address: _____
Patient Phone: _____ Other Phone: _____
Parent Mobile Phone: _____ Email Address: _____

Parent's Marital Status: Single Married Divorced Widowed Who does child live with: _____

How would you like us to contact you during the day? (circle one) Home Cell Work Email

Parent Information for Minors

Father: _____ Spouse: _____
Address _____ Home phone: _____
City, State, Zip code: _____ Mobile phone: _____
Employer: _____ Work phone: _____
Method for Confirmations: **(Circle one):** Text or Email or both Email: _____

Mother: _____ Spouse: _____
Address _____ Home phone: _____
City, State, Zip code: _____ Mobile phone: _____
Employer: _____ Work phone: _____
Method of Confirmations: **(Circle one):** Text or Email or both Email: _____

General Information

Who can we thank for your referral? _____
What don't you like about your smile? _____
What are the patient's hobbies/interests? _____
What school does your child attend? _____
Names of other family member seen at our office? _____

Dentist/Physician information

Dentist Name: _____ Dentist Phone: _____
Dental Office Location _____
Last cleaning date: _____
Is the patient currently under the care of a physician? □ Yes □ No
If yes, please explain _____

Insurance Information Do you have Dental Insurance? □ Yes □ No If yes, please fill in the information below

Subscriber Name: _____ Relation to patient: _____
Employer: _____ Subscriber ID # or SS#: _____
Insurance Company: _____ Subscriber Date of Birth: _____
Insurance address: _____ Policy group number: _____
Insurance city, state, zip _____ Insurance phone number: _____

Subscriber Name: _____ Relation to patient: _____
Employer: _____ Subscriber ID # or SS#: _____
Insurance Company: _____ Subscriber Date of Birth: _____
Insurance address: _____ Policy group number: _____
Insurance city, state, zip _____ Insurance phone number: _____

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Patient's Dental/Medical History (Please complete all questions. Write additional information if necessary.)

Please check the main concerns below:

□ Crowding	□ Overbite	□ Protrusion of teeth	□ Misalignment	□ Receding jaw	□ Prominent jaw
□ Gummy smile	□ Spacing	□ Gum disease/recession	□ Missing teeth	□ Jaw dysfunction	□ Mouth too small
□ Clicking in jaw	□ Headaches	□ Irregular shaped teeth	□ Facial pain	□ Neck pain	□ Jaw pain
□ Crossbite	□ Underbite	□ Irregular facial proportions	□ Openbite	□ Impacted teeth	□ Finger/thumb sucking

List other family members with same dental problems? _____

Does the patient have pain/clicking in the jaw joints? □ Yes □ No If yes, which side? □ Right □ Left □ Both

Does the patient grind/clench teeth? □ Yes □ No □ Unsure Does the patient have difficulty chewing? □ Yes □ No

Injury to face or teeth? □ Yes □ No If yes, please explain: _____

Has the patient been told they have a tongue thrust swallowing pattern? □ Yes □ No

Has the patient had a previous orthodontic exam/consultation? □ No □Yes: when _____

Has the patient ever had orthodontic treatment? □ Yes □ No Explain: _____

What is the patient's interest in orthodontic treatment? □ Wants treatment □ Willing if necessary □ Unwilling but agrees □ Unwilling

How is the patient's general health? □ Excellent □ Good □ Fair □ Poor

Has the patient reached puberty? □ Yes □ No If yes, approximate date: _____

Does the patient smoke? □ Yes □ No

Is there anything in the patient's medical history that we should be aware? □ Yes □ No

If yes, please explain: _____

Does the patient exhibit any developmental delays? □ Yes □ No If yes, please explain: _____

List all medications the patient is currently taking: _____

Is the patient allergic to…?

Dental Anesthetics	□ Yes	□ No	Tetracycline	□ Yes	□ No	Nickel	□ Yes	□ No
Penicillin	□ Yes	□ No	Aspirin	□ Yes	□ No	Latex	□ Yes	□ No
Erythromycin	□ Yes	□ No	Other: _____					

Has the patient ever had or been treated for:

Heart problems	□ Yes	□ No	Cancer	□ Yes	□ No	Epilepsy/Convulsions	□ Yes	□ No
Blood disorders	□ Yes	□ No	Hepatitis	□ Yes	□ No	Heart murmur	□ Yes	□ No
Kidney problems	□ Yes	□ No	Arthritis	□ Yes	□ No	HIV/AIDS	□ Yes	□ No
Sinus problems	□ Yes	□ No	Diabetes	□ Yes	□ No	Tuberculosis	□ Yes	□ No
Breathing difficulty	□ Yes	□ No	Asthma	□ Yes	□ No	Fever blisters	□ Yes	□ No
Blood transfusion	□ Yes	□ No	Fainting	□ Yes	□ No	Rheumatic fever	□ Yes	□ No
Liver disease	□ Yes	□ No	Ulcers	□ Yes	□ No	Severe headaches	□ Yes	□ No
Tonsillitis	□ Yes	□ No	Snoring	□ Yes	□ No	Tonsils Removed	□ Yes	□ No
High blood pressure	□ Yes	□ No	Low blood pressure	□ Yes	□ No	Autoimmune disorder	□ Yes	□ No
Adenoids removed	□ Yes	□ No	Blood disease	□ Yes	□ No	Sleep disturbance	□ Yes	□ No
Eating disorder	□ Yes	□ No	Mouth-breathing	□ Yes	□ No			

Other medical problems:_____

Parent/Guardian name: _____ Date: _____

Signature: _____ Relationship to patient: _____

It is extremely important to inform our office of any changes in medical history.