AVERY ORTHODONTICS

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

Chart:

Patient Information **DATE:**

Patient Name: _____

Nickname: _____ Date of Birth: _____

Social Security number: _____ Gender: _____

Address: _____

Home Phone: _____ Work Phone: _____

Mobile Phone: _____ Email address: _____

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

Dentist/Physician information

Dentist Name: _____ Dentist Phone: _____

Last cleaning date: _____

Physician Name: _____ Physician Phone: _____

Is the patient currently under the care of a physician? □ Yes □ No

If yes, please explain _____

Insurance Information/Parent Information (If patient is a minor)

Father's Name: _____ Social Security number: _____

Address _____ Date of Birth: _____

City, State, Zip code: _____ Home phone: _____

Employer: _____ Work phone: _____

Insurance company: _____ Mobile phone: _____

Insurance address: _____ Insurance phone number _____

Insurance city, state, zip _____ Insurance group number _____

Spouse: _____ _____

Mother's Name: _____ Social Security number _____

Address _____ Date of Birth _____

City, State, Zip code: _____ Home phone: _____

Employer: _____ Work phone: _____

Insurance company: _____ Mobile phone: _____

Insurance address: _____ Insurance phone number _____

Insurance city, state, zip _____ Insurance group number _____

Spouse: _____ _____

Siblings' Names and Ages:

_____

_____

_____

Parent/Guardian name: _____ Date: _____

Signature: _____

Relationship to patient: _____

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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.