MICHAEL O. WILLIAMS, D.D.S., P.A. ORTHODONTIC ACQUAINTANCE FORM

PATIENT INFORMATION					DATE
PATIENT'S FIRST NAME	M.ILAST NAME				
NICKNAME	DATE OF	BIRTH:		AGE	SEX
ADDRESS		CITY		STATE	ZIP
HOME PHONE	CELLULAF	R PHONE		_WORK PHONE	
EMAIL ADDRESS					
DENTIST		REFERRED B	Υ		<u></u>
RESPONSIBLE PARTY					
NAME		DAT	TE OF BIRTH	SOC. SEC. #_	<u>, , , , , , , , , , , , , , , , , , , </u>
ADDRESS		CITY		STATE	ZIP
MARITAL STATUS SINGLE					
EMPLOYED BY				OCCUPATION _	· · · · · · · · · · · · · · · · · · ·
BUSINESS ADDRESS			BUSIN	IESS TELEPHONE _	1
SPOUSE'S NAME			SPOU	SE'S TELEPHONE	
SPOUSE'S EMPLOYER				OCCUPATION_	
SPOUSE'S EMPLOYER ADDRESS			BUSIN	IESS TELEPHONE_	
PRIMARY INSURANCE INFORMATI	ION				
NAME OF INSURANCE COMPANY					
CLAIMS ADDRESS				TELEPHONE #	
SUBSCRIBER'S NAME		DAT	E OF BIRTH	SOC. SEC. #	
MEMBER IDENTIFICATION NO			GROUP NO.		
SECONDARY INSURANCE INFORMA	ATION				
NAME OF INSURANCE COMPANY					
CLAIMS ADDRESS				TELEPHONE #	
SUBSCRIBER'S NAME					
MEMBER IDENTIFICATION NO					

MEDICAL HISTORY

3. WI 4. HA	HAT WAS THE PURPOSE OF THE		E?			NO 🗆	
4. HA		VISIT TO V		ARE YOU IN GOOD HEALTH?			
	AVE YOU EVER HAD A SEVERE II	1131111311	OUR PHYSICIAN?	·			
5. CH	HAVE YOU EVER HAD A SEVERE ILLNESS?					NO 🗆	
	HECK THOSE ITEMS WHICH YOU	NOW ARE	OR HAVE EVER	BEEN TREATED FOR:			
A. /	ANEMIA	YES 🗆	NO 🗆	P. RHEUMATIC FEVER	YES 🗆	NO 🗆	
В. А	ARTHRITIS OR JOINT DISEASE	YES 🗆	NO 🗆	Q. TUBERCULOSIS	YES 🗆	NO □	
C. /	ASTHMA	YES 🗆	NO 🗆	R. SEXUALLY TRANSMITTED DISEASE		NO □	
D. E	BONE DISORDERS	YES 🗆	NO 🗆	S. HAVE YOU BEEN TESTED FOR AIDS	YES []	NO 🗆	
E. 0	CANCER	YES 🗆	NO □	T. HEPATITIS	YES []	NO 🗆	
F. (DIZZINESS	YES 🗆	NO 🗆	ENDOCRINE PROBLEMS			
G. 1	EPILEPSY	YES 🗆	NO 🗆	1. THYROID	YES []	NO 🗆	
Н. 1	FAINTING	YES 🗆	NO 🗆	2. DIABETES	YES []	NO 🗆	
l.	HEAD AND NECK PAIN	YES 🗆	NO 🗆	3. OTHER			
J . 1	HEART DISEASE	YES 🗆	NO 🗆	DRUG SENSITIVITIES	_		
K. 1	KIDNEY INVOLVEMENT	YES 🗆	NO 🗆	1. NOVOCAIN	YES []	NO 🗆	
	LIVER DISEASE	YES 🗆	NO 🗆	2. PENICILLIN	YES 🗆	NO 🗆	
_	NERVOUSNESS		NO 🗆	3. ASPIRIN	YES 🗆	NO 🗆	
****		YES 🗆	NO 🗆	4. CODEINE	YES 🗆	NO 🗆	
	RESPIRATORY DISORDERS		NO 🗆	5. OTHER			
6. LIS	ST ALL DRUGS OR MEDICATION N	IOW BEING	TAKEN:				
							
						·	
				RTED MENSTRUATING? 🗆 BOYS— HAS HIS	VOICE CHA	NGED 🗆	
HE	FIGHT:			WEIGHT:			

DENTAL HISTORY

DO YOU HAVE ANY SPEECH PROBLEMS?	HAS THERE BEEN ANY	INJURIES TO THE F	ACE, MOUTH OR TEETH I	DURING THE PAST 12 MO	NTHS?	YES 🗆	NO.□
DO YOU HAVE ANY EXTRA PERMANENT TEETH? VES □ NO □ HAS PATIENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE? HAS PATIENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE? HAVE SETHER PARENT HAD DRITHODONITIC TREATMENT? LIST ANY MUSICIAL INSTRUMENTS PLAYED. AN ARE YOU MISSING ANY TEETH? HAVE YOU EVER HAD: A ORTHODONITIC TREATMENT? B. ORAL SURGERY? C. PERIODONITAL TREATMENT? P. YES □ NO □ C. PERIODONITAL TREATMENT? P. YES □ NO □ PROBLEMS OF THE JAW.—HAVE YOU EVER EXPERIENCED: A CLICKING OF THE JAW.—HAVE YOU EVER EXPERIENCED: A CLICKING OF THE JAW.—HAVE YOU EVER EXPERIENCED: A CLICKING OF THE JAW. B. PAIN MOINT, EAR, SIDE OF FACE? C. DIFFICULTY IN OPENING AND CLOSING? D. DIFFICULTY IN OPENING AND CLOSING? B. PAIN MOINT, EAR, SIDE OF FACE? YES □ NO □ D. DIFFICULTY IN OPENING AND CLOSING? YES □ NO □ A BITE YOUR FINGERNAILS? B. CLICK OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? C. BITE YOUR FINGERNAILS? P. C. BITE YOUR POBLECTS WITH THE TEETH (SUCH AS PENCILS, PIPE, PINS, NAILS, FINGERNAILS)? P. FEGUENCY PROJUCT FIRST BECOME AWARE OF YOUR ORTHODONTIC PROBLEM? REASON FOR CONSULTATION: DATE: SIGNATURE: OFFICE USE ONLY RESUME MEDICAL HISTORY ORDER OF IMPORTANCE TO THE PATIENT: REFERRAL SOURCES: ORDER OF IMPORTANCE TO THE PATIENT: REFERRAL SOURCES: ORDER OF IMPORTANCE TO THE PATIENT: ORTHODONTICS FORM SAFELY OF THE PRODONTICT PROBLEM? PERIODONTICS PERIODONTICS PERIODONTICS PERMOSTRETICS GREENAL DENTITY PERIODONTICT PERIODONTICS PERMOSTRETICS GREENAL SURGER PARTICULTY PERIODONTICS PERMOSTRETICS GREENAL SURGER PROBLEMS OF PACES OF PACES OF THE PARTIENT ORTHODONTICS PERMOSTRETICS GREENAL SURGER PROBLEMS OF PACES OF THE PARTIENT ORTHODONTICS PERMOSTRETICS GREENAL SURGER PROBLEMS OF THE PACES OF T	DO YOU HAVE ANY SPE	ECH PROBLEMS?_				YES 🗆	NO 🗆
MAS PATENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE? ALSE ETHER PARENT HAD ORTHODONTIC TREATMENT? LASE ETHER PARENT HAD ORTHODONTIC TREATMENT? LATE YOU MISSING ANY TEETH? AND COMMISSING ANY TEETH? AND COMMISSING ANY TEETH? AND COMMISSING ANY TEETH? AND COMMISSING ANY TEETH WHITE AND COMMISSING ANY TEETH WHITE ADJUSTED? C. PERIODONTAL TREATMENT? D. YOUR TEETH GROUND OR THE BITE ADJUSTED? E. WORN BITE PLATE OR OTHER APPLIANCE? A. CLICKING OF THE JAW? A. CLICKING OF THE JAW? C. DIFFICULTY IN CHEWING? A. CLICKING OF THE JAW? YES COMMISSING ANY TEETH WHILE AWAKE OR ASLEEP? B. PAIN NOINT, EAR, SIDE OF FACE)? C. DIFFICULTY IN CHEWING? HABITS—DOYOU. B. PAIN NOINT, EAR, SIDE OF FACE)? C. DIFFICULTY IN CHEWING? HABITS—DOYOU. C. DIFFICULTY IN CHEWING? B. CLICKING OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? C. DIFFICUL POR OR CHEEKS REGULARLY? D. HOLD FOREIGN OBJECTS WITH THE TEETH (SUCH AS PENGILS, PIPE, PINS, NAILS, FINGERNAILS)? FREQUENCY L. CLATTON WHEN DID YOU FIRST BECOME AWARE OF YOUR ORTHODONTIC PROBLEM? REASON FOR CONSULTATION: DATE: SIGNATURE: DETAIL HISTORY ORDER OF IMPORTANCE TO THE PATIENT: REFERRAL SOURCES: OFFICE USE ONLY RESUME MEDICAL HISTORY ORDER OF IMPORTANCE TO THE PATIENT: REFERRAL SOURCES: FRIEDONTIST PERIODONTIST PERIODONTIST	DO YOU HAVE ANY EXT	RA PERMANENT TE	ETH?			YES 🗆	NO 🗆
MAS ETHER PARENT HAD ORTHODONTIC TREATMENT? VES NO ARE YOU MISSING ANY TEETH? A ORTHODONTIC TREATMENT? B. ORAL SURGERY? C. PERIODONTAL TREATMENT? E. WORN BITE PLATE OR OTHER APPLIANCE? PROBLEMS OF THE JAW—HAVE YOU EVER EXPERIENCED: A CLICKING OF THE JAW—HAVE YOU EVER EXPERIENCED: B. PAIN HOINT, EAR, SIDE OF FACE? C. DIFFICULTY IN OPENING AND CLOSING? D. DIFFICULTY IN OPENING AND CLOSING? C. BITE YOUR PINGERNAILS? B. CHICK OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? D. NO CLOSION BEACTH WITH THE TEETH (SUCH AS PENCILS, PIPE, PINS, NAILS, FINGERNAILS)? FREQUENCY FREQUENCY WHEN DID YOU FIRST BECOME AWARE OF ASLEEP? OFFICE USE ONLY REASON FOR CONSULTATION: DENTAL HISTORY DENTAL HISTORY ORDER OF IMPORTANCE TO THE PATIENT: REFERRAL SOURCES: ORTHODONTIST ORTHODONTIST PERIODONTIST PERIODONTIST ORTHODONTIST PERIODONTIST PERIODONTIST PERIODONTIST ORTHODONTIST ORTHODONTIST PERIODONTIST ORTHODONTIST PERIODONTIST PERIODONTIST ORTHODONTIST ORTHODONTIST PERIODONTIST ORTHODONTIST ORTHODONTIST PERIODONTIST PERIODONTIST ORTHODONTIST ORTHODONTIST PERIODONTIST ORTHODONTIST ORTHODONTIST ORTHODONTIST PERIODONTIST ORTHODONTIST ORTHODONTIST ORTHODONTIST PERIODONTIST ORTHODONTIST PERIODONTIST ORTHODONTIST PERIODONTIST ORTHODONTIST PERIODONTIST PERIODONTIST PERIODONTIST PERIODONTIST ORTHODONTIST PERIODONTIST PERIODONTIST PERIODONTIST PERIODONTIST PERIODONTIST PERIODONTIST PERIODONTIST PERIODONTIST ORTHODONTIST PERIODONTIST PERIODONTIST PERIODONTIST PERIODONTIST PERIODONTIST PERIODONTIST PERIODONTIST PERIODONTIST PRICHOPERS PASS ON CO. C. M. C.	HAS PATIENT EVER SUC	CKED A THUMB OR	FINGERS? UNTIL WHAT	AGE?		YES 🗆	NO 🗆
LIST ANY MUSICAL INSTRUMENTS PLAYED ARE YOU MISSING ANY TEETH? A ORTHODONTIC TREATMENT? B. ORAL SURGERY? C. PERIODONTAL TREATMENT? D. YOUR TEETH GROUND OR THE BITE ADJUSTED? E. WORN BITE PLATE OR OTHER APPLIANCE? PROBLEMS OF THE JAW? A CLICKING OF THE JAW? C. DIFFICULTY IN CHEWING? HABITS—DO YOU: A CLICKING OF THE JAW? D. DIFFICULTY IN CHEWING? HABITS—DO YOU: A DITY YOUR PRINGERNAILS? B. CLINGH OR GINNO YOUR TEETH WHILE AWAKE OR ASLEEP? C. DIFFICULTY OR PRINGERNAILS? B. CLINGH OR GINNO YOUR TEETH WHILE AWAKE OR ASLEEP? D. HOUTH BREATHE WHILE AWAKE OR ASLEEP? D. HOUTH BREATHE WHILE AWAKE OR ASLEEP? DO YOU HAVE HEADACHES? FREQUENCY LOCATION WHEN DID YOU FIRST BECOME AWARE OF YOUR ORTHODONTIC PROBLEM? MARITS—BROWN FOR CONSULTATION: DATE: SIGNATURE: OFFICE USE ONLY RESUME MEDICAL HISTORY ORDER OF IMPORTANCE TO THE PATIENT: REFERRAL SOURCES: ORTHODONTICS PRINDONTICS PRINDON	HAS EITHER PARENT H	AD ORTHODONTIC	TREATMENT?			YES 🗆	NO 🗆
ARE YOU MISSING ANY TEETH? YES	LIST ANY MUSICAL INST	TRUMENTS PLAYED)				
HAVE YOU EVER HAD: A. ORTHODONTIC TREATMENT?							NO 🗆
A ORTHODONTIC TREATMENT? YES NO COUNTY B. ORAL SURGERY? YES NO COUNTY B. ORAL SURGERY? YES NO COUNTY TREATMENT? YES NO COUNTY TEATH GROUND OR THE BITE ADJUSTED? YES NO COUNTY TEATH GROUND OR THE BITE ADJUSTED? YES NO COUNTY TEATH GROUND OR THE BITE ADJUSTED? YES NO COUNTY TEATH GROUND OR THE BITE ADJUSTED? YES NO COUNTY TEATH GROUND OR THE BITE ADJUSTED? YES NO COUNTY TEATH GROUND OR THE JAW? YES NO COUNTY THE JAW? YES NO COUNTY TO COUNTY THE							
B. ORAL SURGERY? C. PERIODONTAL TREATMENTT D. YOUR TEETH GROUND OR THE BITE ADJUSTED? E. WORN BITE PLATE OR OTHER APPLANCE? E. WORN BITE PLATE OR OTHER APPLANCE? PROBLEMS OF THE JAW—HAVE YOU EVER EXPERIENCED: A. CLICKING OF THE JAW? B. PAIN LIGHT, SAR, SIDE OF FACE? C. DIFFICULTY IN OPENING AND CLOSING? D. DIFFICULTY IN OPENING AND CLOSING? B. CLINCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? C. BITE YOUR FINGERNAILS? B. CLINCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? D. HABITS—DO YOU: A. BITE YOUR FINGERNAILS? B. CLINCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? D. HOLD FOREIGN OBJECTS WITH THE TEETH (SUCH AS PENCILS, PIPE, PINS, NAILS, FINGERNAILS)? YES NO E. MOUTH BREATHE WHILE AWAKE OR ASLEEP? YES NO DO YOU HAVE HEADACHES? FREQUENCY LOCATION WHEN DID YOU FIRST BECOME AWARE OF YOUR ORTHODONTIC PROBLEM? PERSUME MEDICAL HISTORY ORDER OF IMPORTANCE TO THE PATIENT: REFERRAL SOURCES: ORTHODONTICS TOTH COSMETICS FACIAL AESTHETICS GENERAL DENTIST ORTHODONTIST PERSONNIST FRIENDRAFLYES ORTHODONTICS TOTH COSMETICS FACIAL AESTHETICS GENERAL DENTIST ORTHODONTIST PERSONNIST FRIENDRAFLYES ORTHODONTICS TOTH COSMETICS PACIAL AESTHETICS GENERAL DENTIST ORTHODONTIST PERSONNIST FRIENDRAFLYES ORTHODONTICS TOTH COSMETICS PACIAL AESTHETICS GENERAL DENTIST ORTHODONTIST PERSONNIST FRIENDRAFLYES ORTHODONTICS SHOPENS SHOPPERS SHO	A. ORTHODONTIC 1	REATMENT?				YES 🗆	NO 🗆
C. PERIODONTAL TREATMENT? D. YOUR TEETH GROUND OR THE BITE ADJUSTED? E. WORN BITE PLATE OR OTHER APPLIANCE? FORDEMS OF THE JAW—HAVE YOU EVER EXPERIENCED: A. CLICKING OF THE JAW? B. PAIN (JOINT, EAR, SIDE OF FACE)? C. DIFFICULTY IN OPENING AND CLOSING? D. DIFFICULTY IN CHEWING? HABITS—DO YOU: A. BITE YOUR FINGERNAILS? B. CLINCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? FORDEMS OR CHECKS REGULARLY? D. HOLD FOREIGN OBJECTS WITH THE TEETH GUICH AS PENCILS, PIPE, PINS, NAILS, FINGERNAILS)? FREQUENCY FREQUENCY FREQUENCY LOCATION WHEN DID YOU FIRST BECOME AWARE OF YOUR ORTHODONTIC PROBLEM? DENTAL HISTORY ORDER OF IMPORTANCE TO THE PATIENT: REFERRAL SOURCES: ORTHODONTICS ORDER OF MPORTANCE TO THE PATIENT: ORTHODONTICS ORGENISM SURGEON FRIENDONTICS PRERODONTICS ORAL SURGEON PERIODONTICS PRERODONTICS OR PRERODONTICS PRERODONTICS OR TRINDOR OF FRIENDONTICS OR PRERODONTICS OR TRINDOR OF FRIENDONTICS OR PRERODONTICS OR TRINDOR OF TRINDOR OTHER SHOPPERS	B. ORAL SURGERY	?				YES []	NO 🗆
D. YOUR TEETH GROUND OR THE BITE ADJUSTED? E. WORN BITE PLATE OR OTHER APPLIANCE? PROBLEMS OF THE JAW — HAVE YOU EVER EXPERIENCED: A. CLICKING OF THE JAW? S. PAIN (JOINT, EAR, SIDE OF FACE)? C. DIFFICULTY IN OPENING AND CLOSING? D. DIFFICULTY IN OPENING AND CLOSING? D. DIFFICULTY IN CHEWING? HABITS—DO YOU: A. BITE YOUR FINGERNAILS? B. CLINCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? C. BITE YOUR LIPS OR CHEEKS REQULARLY? D. HOLD FOREIGN OBJECTS WITH THE TEETH ISUCH AS PENCILS, PIPE, PINS, NAILS, FINGERNAILS)? PESS NO DO DO YOU HAVE HEAD ACHES? FREQUENCY LOCATION WHEN DID YOU FIRST BECOME AWARE OF YOUR ORTHODONTIC PROBLEM? PRESUME MEDICAL HISTORY DENTAL HISTORY ORDER OF IMPORTANCE TO THE PATIENT: REFERRAL SOURCES: ORTHODONTICS TOOTH COSMETICS FACIAL AESTHETICS GENERAL DENTIST ORTHODONTIST PERIODONTIST ORTHODONTIST PERIODONTIST ORTHODONTICS FRIEND RELATIVE SURPERS SHOPPERS	C. PERIODONTAL T	REATMENT?				YES U	NO 🗆
E. WORN BITE PLATE OR OTHER APPLIANCE? PROBLEMS OF THE JAW — HAVE YOU EVER EXPERIENCED: A. CLICKING OF THE JAW — HAVE YOU EVER EXPERIENCED: A. CLICKING OF THE JAW — MAYE YOU EVER EXPERIENCED: A. CLICKING OF THE JAW — MAYE YOU EVER EXPERIENCED: A. CLICKING OF THE JAW — MAYE YOU EVER EXPERIENCED: A. CLICKING OF THE JAW — YES NO D. DIFFICULTY IN OPENING AND CLOSING? YES NO D. DIFFICULTY IN CHEWING? A. BITE YOUR FINGERNAILS? YES NO B. CLINCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? C. BITE YOUR LIPS OR CHEEKS REGULARLY? D. HOLD FOREIGN OBJECTS WITH THE TEETH (SUCH AS PENCILS, PIPE, PINS, NAILS, FINGERNAILS)? YES NO D. HOLD FOREIGN OBJECTS WITH THE TEETH (SUCH AS PENCILS, PIPE, PINS, NAILS, FINGERNAILS)? YES NO DO YOU HAVE HEADACHES? FREQUENCY LOCATION WHEN DID YOU FIRST BECOME AWARE OF YOUR ORTHODONTIC PROBLEM? DATE: SIGNATURE: DATE: SIGNATURE: OFFICE USE ONLY RESUME MEDICAL HISTORY DENTAL HISTORY ORDER OF IMPORTANCE TO THE PATIENT: REFERRAL SOURCES: ORTHODONTICS TOOTH COSMETICS FACIAL AESTHETICS GENERAL DENTIST ORTHODONTIST PERIODONTIST PRIEDORIFICS TOTH COSMETICS PREPROSTHETICS GENERAL DENTIST ORTHODONTIST PRIEDORIFICS BURDER BY A BU	D. YOUR TEETH GR	OUND OR THE BITE	ADJUSTED?			YES 🗆	NO 🗆
PROBLEMS OF THE JAW—HAVE YOU EVER EXPERIENCED: A. CLICKING OF THE JAW? B. PAIN (JOINT, EAR, SIDE OF FACE)? C. DIFFICULTY IN OPENING AND CLOSING? D. DIFFICULTY IN OPENING AND CLOSING? D. DIFFICULTY IN CHEWING? HABITS—DO YOU: A. BITE YOUR FINGERNAILS? B. CLINCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? C. BITE YOUR FINS OR CHEEKS REGULARLY? D. HOLD FOREIGN OBJECTS WITH THE TEETH (SUCH AS PENCILS, PIPE, PINS, NAILS, FINGERNAILS)? YES DNO DO YOU HAVE HEADACHES? FREQUENCY LOCATION WHEN DID YOU FIRST BECOME AWARE OR ASLEEP? PRESUME MEDICAL HISTOY DENTAL HISTORY DENTAL HISTORY ORDER OF IMPORTANCE TO THE PATIENT: REFERRAL SOURCES: GRIFRODONTICS TOOTH COSMETICS PACINAL ASSINETICS GENERAL DENTIST OR THODONTIST PERIODONTIST PRIEND/RELATIVE SUPPRESS ORALL SURRECHN PLASTIC SURGEON FRIEND/RELATIVE SUPPRESS ORALL SURRECHN PERIODONTICS PREPROSTHETICS GENERAL DENTIST OR THODONTIST PERIODONTIST PERIODONTIST PERIODONTIST PERIODONTIST PERIODONTICS PREPROSTHETICS GENERAL DENTIST OR THODONTIST PERIODONTIST PERIODON	E. WORN BITE PLAT	TE OR OTHER APPL	IANCE?			YES 🗆	NO 🗆
A. CLICKING OF THE JAW? B. PAIN (JOINT, EAR, SIDE OF FACE)? C. DIFFICULTY IN OPENING AND CLOSING? D. DIFFICULTY IN OPENING AND CLOSING? YES O NO O D. DIFFICULTY IN CHEWING? HABITS—DO YOU: A. BITE YOUR FINGERNAILS? B. CLINCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? C. BITE YOUR LIPS OR CHEEKS REGULARLY? D. HOLD FOREIGN OBJECTS WITH THE TEETH (SUCH AS PENCILS, PIPE, PINS, NAILS, FINGERNAILS)? YES O NO O E. MOUTH BREATHE WHILE AWAKE OR ASLEEP? YES NO O DO YOU HAVE HEADACHES? FREQUENCY LOCATION WHEN DID YOU FIRST BECOME AWARE OF YOUR ORTHODONTIC PROBLEM? PRESUME MEDICAL HISTORY DENTAL HISTORY ORDER OF IMPORTANCE TO THE PATIENT: REFERRAL SOURCES: ORTHODONTICS TOTH COSMETICS FACIAL ASSTNETICS GENERAL DENTIST ORTHODONTIST PERIODONTIST PERIODONTIST ORTHODONTICS TOTH COSMETICS PREPROSTHETICS GENERAL DENTIST ORTHODONTIST PERIODONTIST PERIODONTIST PERIODONTICS PREPROSTHETICS GENERAL DENTIST ORTHODONTIST PERIODONTIST PERIODONTIST PERIODONTIST PERIODONTICS TOTH COSMETICS PREPROSTHETICS GENERAL DENTIST ORTHODONTIST PERIODONTIST PERIODON	PROBLEMS OF THE JAV	V—HAVE YOU EVER	EXPERIENCED:				
B. PAIN (JOINT, EAR, SIDE OF FACE)? C. DIFFICULTY IN OPENING AND CLOSING? D. DIFFICULTY IN CHEWING? HABITS—DO YOU: A. BITE YOUR FINGERNAILS? B. CLINCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? C. BITE YOUR LIPS OR CHEEKS REGULARLY? D. HOLD FOREIGN OBJECTS WITH THE TEETH (SUCH AS PENCILS, PIPE, PINS, NAILS, FINGERNAILS)? FREQUENCY FREQUENCY LOCATION WHEN DID YOU HAVE HEADACHES? PERSUME MEDICAL HISTORY DENTAL HISTORY DENTAL HISTORY ORDER OF IMPORTANCE TO THE PATIENT: ORTHODONTICS TOOTH COSMETICS FACIAL AESTHETICS GENERAL DENTIST ORTHODONTIST ORTHODONTIST ORTHODONTICS PROPERS OFFICE USE ONLY RESUME MEDICAL HISTORY ORDER OF IMPORTANCE TO THE PATIENT: ORTHODONTICS TOOTH COSMETICS FACIAL AESTHETICS GENERAL DENTIST ORTHODONTIST PERIODONTIST ORTHODONTIST ORTHODONTICS PROPERS OFFICE USE OR SURGEON PLASTIC SURGEON FRIEND/RELATIVE SHOPPERS	A. CLICKING OF TH	EJAW?				YES 🗆	NO 🗆
C. DIFFICULTY IN OPENING AND CLOSING? D. DIFFICULTY IN CHEWING? HABITS—DO YOU: A. BITE YOUR FINSERNAILS? B. CLINCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? C. BITE YOUR LIPS OR CHEEKS REGULARLY? D. HOLD FOREIGN OBJECTS WITH THE TEETH (SUCH AS PENCILS, PIPE, PINS, NAILS, FINGERNAILS)? FINGERNAILS? FINGERNAILS? YES DNOD DO YOU HAVE HEADACHES? FREQUENCY LOCATION WHEN DID YOU FIRST BECOME AWARE OF YOUR ORTHODONTIC PROBLEM? PREASON FOR CONSULTATION: DATE: OFFICE USE ONLY RESUME MEDICAL HISTORY ORDER OF IMPORTANCE TO THE PATIENT: REFERRAL SOURCES: ORTHODONTICS TOOTH COSMETICS FACIAL AESTHETICS GENERAL DENTIST ORTHODONTIST PRIND/PELATIVE SHOPPERS OFFICE USE OR OTHER SHORD FRIEDDONTIST PRIND/PELATIVE OCCLUSION PERIODONTICS PREPROSTHETICS GENERAL DENTIST ORTHODONTIST PRIND/PELATIVE OCCLUSION PERIODONTICS PREPROSTHETICS GENERAL DENTIST ORTHODONTIST PRIND/PELATIVE SHOPPERS	B. PAIN (JOINT, EAR	R. SIDE OF FACE)?				YES 🗆	NO 🗆
D. DIFFICULTY IN CHEWING? HABITS—DO YOU: A. BITE YOUR FINGERNAILS? B. CLINCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? C. BITE YOUR LIPS OR CHEEKS REGULARLY? D. HOLD FOREIGN OBJECTS WITH THE TEETH (SUCH AS PENCILS, PIPE, PINS, NAILS, FINGERNAILS)? E. MOUTH BREATHE WHILE AWAKE OR ASLEEP? LOO YOU HAVE HEADACHES? FREQUENCY LOCATION WHEN DID YOU FIRST BECOME AWARE OF YOUR ORTHODONTIC PROBLEM? PREASON FOR CONSULTATION: DATE: SIGNATURE: OFFICE USE ONLY RESUME MEDICAL HISTORY DENTAL HISTORY ORDER OF IMPORTANCE TO THE PATIENT: ORTHODONTICS TOTH COSMETICS FACIAL AESTHETICS GENERAL DENTIST ORTHODONTIST PRIODONTIST PRIODONTIST ORTHODONTICS PRICHOPERS OCCLUSION PERIODONTICS PREPROSTHETICS ORAL SURGEON PLASTIC SURGEON FRICHO/RELATIVE SHOPPERS	C. DIFFICULTY IN O	PENING AND CLOS	ing?			YES []	NO 🗆
HABITS—DO YOU: A. BITE YOUR FINGERNAILS? B. CLINCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? C. BITE YOUR COREIGN OR CHEEKS REGULARLY? D. HOLD FOREIGN OBJECTS WITH THE TEETH (SUCH AS PENCILS, PIPE, PINS, NAILS, FINGERNAILS)? F. MOUTH BREATHE WHILE AWAKE OR ASLEEP? YES NOOD ON THE MOUTH OF THE TEETH (SUCH AS PENCILS, PIPE, PINS, NAILS, FINGERNAILS)? FREQUENCY LOCATION WHEN DID YOU FIRST BECOME AWARE OF YOUR ORTHODONTIC PROBLEM? DATE: SIGNATURE: OFFICE USE ONLY RESUME MEDICAL HISTORY DENTAL HISTORY ORDER OF IMPORTANCE TO THE PATIENT: REFERRAL SOURCES: ORTHODONTICS TOOTH COSMETICS FACIAL AESTHETICS GENERAL DENTIST ORTHODONTIST PERIODONTIST ORTHODONTICS TOOTH COSMETICS FACIAL AESTHETICS GENERAL DENTIST ORTHODONTIST PERIODONTIST ORTHODONTICS PREPROSTHETICS GRAL SURGEON PLASTIC SURGEON FRIEND/RELATIVE OCCLUSION PERIODONTICS PREPROSTHETICS GRAL SURGEON PLASTIC SURGEON FRIEND/RELATIVE SHOPPERS	D. DIFFICULTY IN C	HEWING?				YES []	NO 🗆
A BITE YOUR FINGERNAILS? B. CLINCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? C. BITE YOUR LIPS OR CHEEKS REGULARLY? D. HOLD FOREIGN OBJECTS WITH THE TEETH (SUCH AS PENCILS, PIPE, PINS, NAILS, FINGERNAILS)? E. MOUTH BREATHE WHILE AWAKE OR ASLEEP? DO YOU HAVE HEADACHES? FREQUENCY LOCATION WHEN DID YOU FIRST BECOME AWARE OF YOUR ORTHODONTIC PROBLEM? REASON FOR CONSULTATION: DATE: OFFICE USE ONLY RESUME MEDICAL HISTORY DENTAL HISTORY ORDER OF IMPORTANCE TO THE PATIENT: ORTHODONTICS TOOTH COSMETICS FACIAL AESTHETICS GENERAL DENTIST ORTHODONTIST PERIODONTIST ORTHODONTIST ORGEON FRIEND/RELATIVE OCCLUSION PERIODONTICS PREPROSTHETICS GRAL DENTIST ORTHODONTIST SHOPPERS	HABITS-DO YOU:						
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C. BITE YOUR LIPS OR CHEEKS REGULARLY? D. HOLD FOREIGN OBJECTS WITH THE TEETH (SUCH AS PENCILS, PIPE, PINS, NAILS, FINGERNAILS)? E. MOUTH BREATHE WHILE AWAKE OR ASLEEP? POD YOU HAVE HEADACHES? FREQUENCY LOCATION WHEN DID YOU FIRST BECOME AWARE OF YOUR ORTHODONTIC PROBLEM? PREASON FOR CONSULTATION: DATE: SIGNATURE: OFFICE USE ONLY RESUME MEDICAL HISTORY DENTAL HISTORY ORDER OF IMPORTANCE TO THE PATIENT: ORTHODONTICS TOOTH COSMETICS FACIAL AESTHETICS GENERAL DENTIST ORTHODONTIST PERIODONTIST OCCUSION PERIODONTICS PREPAGES HEIGH SHOPPERS BENNER WAS AND THE SHOPPERS ORAL SURGEON PLASTIC SURGEON FRIEND/RELATIVE	B. CLINCH OR GRIN	D YOUR TEETH WH	ILE AWAKE OR ASLEEP	?		YES 🗆	NO 🗆
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OCCLUSION PERIODONTICS PREPROSTHETICS ORAL SURGEON PLASTIC SURGEON FRIEND/RELATIVE				GENERAL DENTIST	ORTHODONTIST	PERIODONTIST	
PENDENT PROPERTY BHONE BY SELE OTHER SHOPPERS			PREPROSTHETICS	ORAL SURGEON	PLASTIC SURGEON	FRIEND/RELATIV	Æ
			OTHER	PHONE BK/SELF	OTHER	SHOPPERS	

DYSFUNCTION EXAM.

PLEASE FILL OUT COMPLETELY—ALL MATERIAL IS CONFIDENTIAL

NAME.	DATE:	
NAME:QUESTIONNAIRE NO. 1	YES	NO
1. DOES IT HURT WHEN YOU CHEW?		
2. DOES IT HURT WHEN YOU OPEN WIDE OR TAKE A BIG BITE?		
2. DOES YOUR JAW MAKE NOISE SO THAT IT BOTHERS YOU OR OTHERS?		
4. DO YOU HAVE EAR PAIN OR PAIN IN FRONT OF THE EARS?	0	
5. DO YOU SUFFER FROM PAIN IN THE FACE, JAWS, EYES, THROAT, NECK, TEMPLES?		
6. DO YOU SUFFER FROM HEADACHES?		
6. DO 100 3011 ENT HOMENE ASTRON		
QUESTIONNAIRE NO. 2	YES	NO
1. DOES THE PAIN OR DISCOMFORT DISTURB YOUR SLEEP?		
2. DOES PAIN OR DISCOMFORT INTERFERE WITH YOUR DAILY ACTIVITIES?		
3. DO YOU TAKE TABLETS FOR RELAXATION? (VALIUM?)	0	
4. DO YOU TAKE TABLETS FOR PAIN OR DISCOMFORT?		
4.00.00	4 .	
QUESTIONNAIRE NO.3	YES	NO
1. HAS ANYONE HEARD YOU GRINDING IN YOUR SLEEP OR ARE YOU AWARE OF IT?		
LESS THAN TWO WEEKS AGO	_	
GREATER THAN TWO WEEKS		
GREATER THAN ONE MONTH	0	0
2. ARE YOU AWARE THAT YOU CLAMP OR "SET" YOUR TEETH?	0	0
3. DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS UPON WAKING IN THE A.M.?		
STIFF JAW?	, O	
SORE JAW OR TEETH?		
CRACKING OR LOCKING OF THE JAW JOINT?	٥	
HEADACHE?	. 0	
4. DOES YOUR JAW "FEEL TIRED" AFTER A BIG MEAL?		
5. MUST YOU CHEW ON ONE SIDE EXCLUSIVELY?	0	
QUESTIONNAIRE NO. 4	YES	NO D
1. HAVE YOU EVER HAD NECK, SHOULDER, OR BACK PAIN?	0	٥
2. HAVE YOU EVER HAD A "WHIPLASH"?	0	-
3. HAVE YOU EVER HAD "NERVOUS STOMACH"OR ULCERS?		0
4. HAVE YOU EVER HAD BOWEL TROUBLE, CONSTIPATION OR COLITIS?	0	
5. DO YOU HAVE ARTHRITIS?		

SIGNATURE: