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

PATIENT INFORMATION **DATE**_____

PATIENT'S FIRST NAME _____ M.I. _____ LAST NAME _____

NICKNAME _____ DATE OF BIRTH: _____ AGE_____ SEX_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

HOME PHONE _____ CELLULAR PHONE _____ WORK PHONE_____

EMAIL ADDRESS_____

DENTIST_____ REFERRED BY_____

RESPONSIBLE PARTY

NAME_____ DATE OF BIRTH_____ SOC. SEC. #_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____

MARITAL STATUS SINGLE_____ MARRIED_____ DIVORCED_____ WIDOWED_____

EMPLOYED BY _____ OCCUPATION _____

BUSINESS ADDRESS _____ BUSINESS TELEPHONE _____

SPOUSE'S NAME _____ SPOUSE'S TELEPHONE _____

SPOUSE'S EMPLOYER _____ OCCUPATION_____

SPOUSE'S EMPLOYER ADDRESS _____ BUSINESS TELEPHONE_____

PRIMARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY _____

CLAIMS ADDRESS _____ TELEPHONE # _____

SUBSCRIBER'S NAME _____ DATE OF BIRTH_____ SOC. SEC. #_____

MEMBER IDENTIFICATION NO. _____ GROUP NO. _____

SECONDARY INSURANCE INFORMATION

NAME OF INSURANCE COMPANY _____

CLAIMS ADDRESS _____ TELEPHONE # _____

SUBSCRIBER'S NAME _____ DATE OF BIRTH_____ SOC. SEC. #_____

MEMBER IDENTIFICATION NO. _____ GROUP NO. _____

MEDICAL HISTORY

1. ARE YOU IN GOOD HEALTH? _____ YES ☐ NO ☐
2. AT PRESENT ARE YOU UNDER MEDICAL CARE? _____ YES ☐ NO ☐
3. WHAT WAS THE PURPOSE OF THE VISIT TO YOUR PHYSICIAN? _____
4. HAVE YOU EVER HAD A SEVERE ILLNESS? _____ YES ☐ NO ☐
5. CHECK THOSE ITEMS WHICH YOU NOW ARE OR HAVE EVER BEEN TREATED FOR:

A. ANEMIA	YES ☐	NO ☐	P. RHEUMATIC FEVER	YES ☐	NO ☐
B. ARTHRITIS OR JOINT DISEASE	YES ☐	NO ☐	Q. TUBERCULOSIS	YES ☐	NO ☐
C. ASTHMA	YES ☐	NO ☐	R. SEXUALLY TRANSMITTED DISEASE	YES ☐	NO ☐
D. BONE DISORDERS	YES ☐	NO ☐	S. HAVE YOU BEEN TESTED FOR AIDS	YES ☐	NO ☐
E. CANCER	YES ☐	NO ☐	T. HEPATITIS	YES ☐	NO ☐
F. DIZZINESS	YES ☐	NO ☐	ENDOCRINE PROBLEMS		
G. EPILEPSY	YES ☐	NO ☐	1. THYROID	YES ☐	NO ☐
H. FAINTING	YES ☐	NO ☐	2. DIABETES	YES ☐	NO ☐
I. HEAD AND NECK PAIN	YES ☐	NO ☐	3. OTHER _____		
J. HEART DISEASE	YES ☐	NO ☐	DRUG SENSITIVITIES		
K. KIDNEY INVOLVEMENT	YES ☐	NO ☐	1. NOVOCAIN	YES ☐	NO ☐
L. LIVER DISEASE	YES ☐	NO ☐	2. PENICILLIN	YES ☐	NO ☐
M. NERVOUSNESS	YES ☐	NO ☐	3. ASPIRIN	YES ☐	NO ☐
N. PROLONGED BLEEDING	YES ☐	NO ☐	4. CODEINE	YES ☐	NO ☐
O. RESPIRATORY DISORDERS	YES ☐	NO ☐	5. OTHER _____		

6. LIST ALL DRUGS OR MEDICATION NOW BEING TAKEN: _____
7. LIST ALLERGIES: _____
8. HAS ANYONE IN YOUR FAMILY HAD DIABETES? _____
9. WOMEN: ARE YOU PREGNANT? _____
10. HAS THE PATIENT REACHED PUBERTY? GIRLS—HAS SHE STARTED MENSTRUATING? ☐ BOYS— HAS HIS VOICE CHANGED ☐

HEIGHT: _____ WEIGHT: _____

GROWTH RATE: SLOW ..... ☐ AVERAGE ..... ☐ FAST ..... ☐

RESEMBLES: MOTHER ..... ☐ FATHER ..... ☐ ADOPTED ..... ☐

DISPOSITION: OBEDIENT ..... ☐ COOPERATIVE ..... ☐ INDEPENDENT ..... ☐ REBELLIOUS ..... ☐

DOES PATIENT HAVE TENDENCY TO COLDS .... ☐ SORE THROATS ....☐ EAR INFECTIONS .... ☐

HAVE TONSILS AND ADENOIDS BEEN REMOVED? YES ☐ NO ☐ WHAT AGE? _____

WAS YOUR CHILD BREAST FED ☐ FORMULA FED ☐

DENTAL HISTORY

HAS THERE BEEN ANY INJURIES TO THE FACE, MOUTH OR TEETH DURING THE PAST 12 MONTHS? YES ☐ NO ☐

DO YOU HAVE ANY SPEECH PROBLEMS? YES ☐ NO ☐

DO YOU HAVE ANY EXTRA PERMANENT TEETH? YES ☐ NO ☐

HAS PATIENT EVER SUCKED A THUMB OR FINGERS? UNTIL WHAT AGE? YES ☐ NO ☐

HAS EITHER PARENT HAD ORTHODONTIC TREATMENT? YES ☐ NO ☐

LIST ANY MUSICAL INSTRUMENTS PLAYED

ARE YOU MISSING ANY TEETH? YES ☐ NO ☐

HAVE YOU EVER HAD:

A. ORTHODONTIC TREATMENT? YES ☐ NO ☐

B. ORAL SURGERY? YES ☐ NO ☐

C. PERIODONTAL TREATMENT? YES ☐ NO ☐

D. YOUR TEETH GROUND OR THE BITE ADJUSTED? YES ☐ NO ☐

E. WORN BITE PLATE OR OTHER APPLIANCE? YES ☐ NO ☐

PROBLEMS OF THE JAW—HAVE YOU EVER EXPERIENCED:

A. CLICKING OF THE JAW? YES ☐ NO ☐

B. PAIN (JOINT, EAR, SIDE OF FACE)? YES ☐ NO ☐

C. DIFFICULTY IN OPENING AND CLOSING? YES ☐ NO ☐

D. DIFFICULTY IN CHEWING? YES ☐ NO ☐

HABITS—DO YOU:

A. BITE YOUR FINGERNAILS? YES ☐ NO ☐

B. CLINCH OR GRIND YOUR TEETH WHILE AWAKE OR ASLEEP? YES ☐ NO ☐

C. BITE YOUR LIPS OR CHEEKS REGULARLY? YES ☐ NO ☐

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? YES ☐ NO ☐

FREQUENCY

LOCATION

WHEN DID YOU FIRST BECOME AWARE OF YOUR ORTHODONTIC PROBLEM?

REASON FOR CONSULTATION:

DATE: SIGNATURE:

OFFICE USE ONLY

RESUME

MEDICAL HISTOY

DENTAL HISTORY

ORDER OF IMPORTANCE TO THE PATIENT:

ORTHODONTICS	TOOTH COSMETICS	FACIAL AESTHETICS
OCCLUSION	PERIODONTICS	PREPROSTHETICS
TMJ	ORTHOGNATHIC	OTHER

REFERRAL SOURCES:

GENERAL DENTIST	ORTHODONTIST	PERIODONTIST
ORAL SURGEON	PLASTIC SURGEON	FRIEND/RELATIVE
PHONE BK/SELF	OTHER	SHOPPERS

DYSFUNCTION EXAM. **MICHAEL O. WILLIAMS, D.D.S., P.A.**

PLEASE FILL OUT COMPLETELY—ALL MATERIAL IS CONFIDENTIAL

NAME: _____ DATE: _____

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?	☐	☐
3. 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?	☐	☐
5. DO YOU SUFFER FROM PAIN IN THE FACE, JAWS, EYES, THROAT, NECK, TEMPLES?	☐	☐
6. DO YOU SUFFER FROM HEADACHES?	☐	☐

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?)	☐	☐
4. DO YOU TAKE TABLETS FOR PAIN OR DISCOMFORT?	☐	☐

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	☐	☐
2. ARE YOU AWARE THAT YOU CLAMP OR "SET" YOUR TEETH?	☐	☐
3. DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS UPON WAKING IN THE A.M.?	☐	☐
STIFF JAW?	☐	☐
SORE JAW OR TEETH?	☐	☐
CRACKING OR LOCKING OF THE JAW JOINT?	☐	☐
HEADACHE?	☐	☐
4. DOES YOUR JAW "FEEL TIRED" AFTER A BIG MEAL?	☐	☐
5. MUST YOU CHEW ON ONE SIDE EXCLUSIVELY?	☐	☐

QUESTIONNAIRE NO. 4	**YES**	**NO**
1. HAVE YOU EVER HAD NECK, SHOULDER, OR BACK PAIN?	☐	☐
2. HAVE YOU EVER HAD A "WHIPLASH"?	☐	☐
3. HAVE YOU EVER HAD "NERVOUS STOMACH"OR ULCERS?	☐	☐
4. HAVE YOU EVER HAD BOWEL TROUBLE, CONSTIPATION OR COLITIS?	☐	☐
5. DO YOU HAVE ARTHRITIS?	☐	☐

SIGNATURE: _____

DATE: _____