O. LEE WILLHAM, D.D.S., M.S.

GET ACQUAINTED QUESTIONNAIRE

Date ____________

The following information is necessary to enable
us to give you the most consideration and the best service possible.
All information is confidential.

PATIENT INFORMATION

Patient's Full Name ______________________ I prefer to be called ____________
Address ______________________ City ____________ State ________ Zip ________
Home Phone (____) ______________ Birthdate ____________ Age ____________
Sex: M F Height ____________ Weight ____________
If patient is a minor, give parent(s) or guardian's name ______________________
Whom may we thank for referring you to our office? ______________________

RESPONSIBLE PARTY INFORMATION

Full Name ______________________ Marital Status ____________
Address ______________________ City ____________ State ________ Zip ________
How long at this address? ____________ Home Phone (____) ______________
Previous Address (if less than 3 yrs.) ______________ City ____________ State ________ Zip ________
Social Security # ____________ Birthdate ____________ Relationship to patient ____________
Employer ______________________ Occupation ____________
Employer Address ______________ City ____________ Work Phone (____) ____________
Spouse's Name ______________________ Relationship to patient ____________
Employer ______________________ Occupation ____________
Employer Address ______________ City ____________ Work Phone (____) ____________
Social Security # ____________ Birthdate ____________
If patient is a minor, patient lives with: Both Parents ___ Father ___ Mother ___ Other ___

DENTAL INSURANCE INFORMATION

Insured's Name ______________________ Social Security # ____________
Insurance Company ______________________ Group No. ____________ Local ________
Insurance Co. Address ______________________ Phone ____________
Do you have double coverage? Y N If yes, complete the following:
Insured's Name ______________________ Social Security # ____________
Insurance Company ______________________ Group No. ____________ Local ________
Insurance Co. Address ______________________ Phone ____________

BACKGROUND INFORMATION

Reason for consultation ______________________
Patient interested in orthodontic treatment? Y N
Patient has had previous orthodontic consultation or treatment? Y N
If yes, where? ______________________ When? ____________
Other family members who are patients of ours ______________________
Patient's father has natural teeth Y N Father been treated Y N
Patient's mother has natural teeth Y N Mother been treated Y N
Does anyone in family have problems similar to patients? Y N
If patient is a minor:
How many sisters? ____________ Ages ____________ How many brothers? ____________ Ages ____________

DENTAL HISTORY

Family Dentist ______________________________ City ______________

Has patient had unfavorable reaction to dental care? Y N

Date of last examination ______________________________ Were X-Rays taken? Y N

Please indicate which pertain to patient:

_____ Thumb sucking (until age ________) _____ Tongue thrusting _____ Mouth breathing

_____ Finger sucking (until age ________) _____ Grinding of teeth _____ Snoring

_____ Lip biting or sucking _____ Clenching of jaw

Please answer the following:

Is patient missing permanent teeth	Y	N	Teeth been removed by dentist	Y	N
Patient had speech or tongue therapy	Y	N	Problems chewing or swallowing food	Y	N
Has frequent headaches	Y	N	Jaw catches or locks when open wide	Y	N
Patient's jaw feels tired after big meal	Y	N			

Patient complains of clicking, pain, or stiffness in jaw joint? Y N

If a yes was indicated, please explain

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MEDICAL HISTORY

Patient's Physician ______________________________ City ______________

Patient's last physical exam ______________________________

Is patient currently under care of a physician? Y N

If so, why? ______________________________

Has the patient had any of the following:

Diabetes	Y	N	Hearing impairment	Y	N	Heart problems	Y	N
Endocrine problems	Y	N	Thyroid problems	Y	N	Prolonged bleeding	Y	N
Asthma	Y	N	Allergies	Y	N	Fainting	Y	N
Anemia	Y	N	Dizziness	Y	N	Bone disorders	Y	N
Nervous disorders	Y	N	Epilepsy	Y	N	Headaches	Y	N
Kidney problems	Y	N	Emotional problems	Y	N	Behavior problems	Y	N

Does or has patient had any communicable disease? Y N HIV? ______ Hepatits B? _____ Other? _____

Does patient have trouble breathing through nose? Y N Does patient suffer from cold sores or canker sores? Y N

Have patient's tonsils or adenoids been removed? Y N Has patient ever been hospitalized? Y N

Does patient have any medical problems not listed above? Y N

Does patient have any allergies or sensitivities to medications? Y N

List below, the patient's reactions to drug or allergy medications.

Female patients only: Are you currently pregnant? Y N Are you taking oral contraceptives? Y N

If a yes was indicated, please explain

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I understand that where appropriate, a credit bureau report may be obtained.

Signature (Parent's signature if minor) ______________________________ Date ______________

Updates (date & initials) ____________ ____________ ____________ ____________