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

_____

_____

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

_____

_____

_____

_____

_____

_____

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

Signature (Parent's signature if minor) _____ Date _____

Updates (date & initials) _____ _____ _____ _____