Date: _____ Acct # _____

Member American Association of Orthodontists

Williams Orthodontics
MICHAEL D WILLIAMS DMD, MS

Member Southern Association of Orthodontists

WELCOME TO OUR OFFICE

"We'd Like To Get To Know You Better!"

This information is necessary so we can meet your orthodontic needs. It is considered strictly confidential.

ADULT PATIENT INFORMATION

Name_____ Age_____ Birthdate: _____ / _____ / _____

Nickname _____ Male _____ Female _____

Address _____ City _____ Zip _____

How long at the above address? _____

Previous Address (if less than 3 years) _____City _____Zip _____

Home Phone _____ Work Phone _____ Cell Phone _____

Would you like to receive TEXT reminders on your cell phone for your future appointments? ☐ YES ☐ NO

Cell phone provider : ☐AT&T ☐Sprint ☐T-Mobile ☐Verizon ☐Metro PCS ☐Other _____

Email _____

Would you like to receive EMAIL reminders for your future appointments? ☐ YES ☐ NO

Social Security # _____-____-_____ Birthdate: ____ /____ / _____

Employer _____ Occupation _____ No. years employed _____

Spouse's Name _____ Work Ph _____

Social Security # _____-____-_____ Birthdate: ____ /____ / _____

Employer _____ Occupation _____ No. years employed _____

Have you had a previous orthodontic consultation? ☐ YES ☐ NO Previous Orthodontic treatment? ☐ YES ☐ NO

If so, when/where? _____ Doctor's Name _____

What is it about your teeth/bite and/or appearance that has brought you to see us? _____

_____

Who may we thank for referring you to our office? _____

EMERGENCY INFORMATION

Name of nearest relative not living with you _____

Ph. _____ Work _____ Cell _____

Address _____City _____ Zip _____

Please Complete Back

DENTAL

Patient's dentist_____Does patient receive regular dental checkups? Y/N

Last dental exam_____Last dental X-rays_____

Other dental specialists_____

Is patient satisfied with past dentistry? Y/N Any unfavorable dental experiences?_____

Please explain_____

How does the patient feel about wearing "braces"?_____

Does anyone else in family have a similar orthodontic problem? Y/N Who?_____

Does the patient currently have, or has the patient ever had any of the following? (Please circle)

Thumb/finger habit/nail or lip biting	Head/neck injury
Missing permanent teeth not due to extraction	Jaw/joint pain/head/neck pain
Periodontal disease	Cold sores/clenching/grinding
Gum surgery/food traps	Adult/baby/wisdom tooth extractions

Is there any other dental information we should know about?_____

_____

MEDICAL

Patient's Physician _____Patient's overall health status? Excellent / Good / Poor

Is the patient allergic to anything (Drugs, food, pollen)?_____

Is the patient presently under medical care? Y/N If yes, what for?_____

_____

Is the patient currently taking any medications? Y/N Please list_____

Has the patient ever been hospitalized? Y/N When/Where?_____

Does the patient currently have , or has the patient ever had any of the following? (Please circle)

Adenoids removed	Drug addiction	Major surgery
AIDS (HIV)	Epilepsy/seizures	Nasal airway problems
Arthritis	Heart problems	Sinus problems
Asthma	Hepatitis	Speech problems
Auto accident	High blood pressure	Tobacco usage
Bleeding disorders	Immune disorders	Tonsils removed
Cancer	Kidney problems	Tuberculosis
Cosmetic surgery	Liver problems	Tubes in ears
Diabetes	Lung problems	

Is there any other medical information we should know about?_____

_____

Signature: _____
Please Sign

Updates: (date & initial) _____ _____ _____ _____