Williams ORTHODONTICS
Your smile is our specialty

Adult

Welcome To Our Office!

Please complete the following to help us better care for you

Name: ______________________ I prefer to be called: ______________________
Gender: __________ Date of Birth: __________ Age: __________
Street: ______________________ City: ______________ Zip: __________
Cell Phone ______________________ Home Phone: ______________________
Other Phone: ______________________ E-mail: ______________________
(for appointment reminders)
What is your preferred method of communication? ☐ Cell ☐ Home ☐ Text ☐ E-mail
Occupation: ______________________ Employer: ______________________

Spouse's Name: ______________________ Cell Phone: ______________________
(if applicable)
Occupation: ______________________ Employer: ______________________

Financially Responsibly Party: ______________________ Relationship to patient: ______________________

Is there an insurance company we can contact for you concerning orthodontic coverage? ☐ Yes ☐ No
Insurance Company Name: ______________________ State: ______________________
(if applicable)
Policy Holder's Name: ______________________ Relationship to patient: ______________________
SS#: ______________________ Date of birth: ______________________

Is there a secondary insurance company which may provide coverage? ☐ Yes ☐ No
Insurance Company Name: ______________________ State: ______________________
(if applicable)
Policy Holder's Name: ______________________ Relationship to patient: ______________________
SS#: ______________________ Date of birth: ______________________

Dentist: ______________________ When was your last general dental exam? ______________________
Whom may we thank for referring you? ______________________

Have any family members received treatment in our office? ☐ Yes ☐ No
Are there any other family members that would benefit from an orthodontic consultation? ☐ Yes ☐ No
Please list the first name and date of birth of dependents in your family:
Name: ______________ DOB: __________ Name: ______________ DOB: __________
Name: ______________ DOB: __________ Name: ______________ DOB: __________

Patient Signature: ______________________________ **Date:** __________

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Medical and Dental History Information

Patient name: ____________________________________

Please check any of the following you presently have or have had:

- ☐ Sleep apnea
- ☐ Heart condition requiring antibiotic premed
- ☐ High blood pressure
- ☐ Artificial joint
- ☐ Stroke
- ☐ Blood or bleeding disorder
- ☐ Anemia
- ☐ Growth disorder
- ☐ Bone disorder
- ☐ Osteoporosis
- ☐ Hormone replacement therapy
- ☐ Bisphosphonate medication
- ☐ Thyroid disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Asthma
- ☐ Epilepsy or seizures
- ☐ Fainting or dizzy spells
- ☐ HIV or AIDS
- ☐ Hepatitis
- ☐ Cold sores
- ☐ Allergies to latex
- ☐ Allergies to plastics
- ☐ Allergies to metals

Are you allergic to any drugs or medications? If so, please list: ____________________________________

Do you have any other disease or condition worth mentioning? If so, please list: ______________________________

Describe your current health: ☐ Good ☐ Fair ☐ Poor

Women: Are you pregnant? ☐ Yes ☐ No Do you anticipate becoming pregnant within the next few years? ☐ Yes ☐ No

Are you aware of any of the following?

- ☐ Popping or clicking in the jaw joint
- ☐ Clenching or grinding
- ☐ Difficulty opening widely
- ☐ Pain in the jaw joint
- ☐ Sore or tired jaw muscles
- ☐ "Tension" headaches
- ☐ Migraine headaches
- ☐ Snoring
- ☐ Tongue thrust

If you answer yes to any of the following, please explain.

Have you had any periodontal or gum problems? ☐ Yes ☐ No ______________________________

Are you having any pain or discomfort? ☐ Yes ☐ No __________________________________

Have there been any injuries to your teeth or mouth? ☐ Yes ☐ No ____________________________

Have you ever been treated by an orthodontist or seen an orthodontist for a consultation? ☐ Yes ☐ No ____________

Please list concerns about your teeth or smile: ____

Which option are you most interested in?

- ☐ Comprehensive orthodontic treatment to address the cosmetic alignment and the bite
- ☐ Limited treatment to straighten the front teeth for cosmetic "smile refresher" only

Which appliance are you most interested in:

☐ Invisalign ☐ Clear ceramic braces ☐ Either option

Are you willing to wear rubber bands if needed for bite correction? ☐ Yes ☐ No

What concerns you about orthodontic treatment? (check all that apply)

- ☐ Appearance of appliances
- ☐ Results
- ☐ Length of treatment time
- ☐ Discomfort
- ☐ Cost
- ☐ Fitting appointments into your schedule

To the best of my knowledge, these answers are true & correct. I will inform the office with any changes in health/medication.

Patient Signature: ____ **Date:** ____________

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ___________________________________, have received a copy of this office's Notice of Privacy Practices.

____
{Please Print Name}

____
{Signature}

____
{Date}

For Office Use Only: We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

☐ Individual refused to sign

☐ Communications barriers prohibited obtaining the acknowledgement

☐ An emergency situation prevented us from obtaining acknowledgement

☐ Other (Please Specify)

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