William B. Miller, DMD
Specialist in Orthodontics

NEW PATIENT INFORMATION

Welcome to our office! Thank you for giving us the opportunity to be of service!

This form is intended to provide us with enough information to perform an initial orthodontic evaluation. When treatment is recommended, full orthodontic records will be made, and a more detailed history form will be necessary.

We sincerely appreciate all referrals to our office! If someone referred you to us, whom may we thank for the referral? _____

Did you locate us easily? Yes/No

Patient's Name: _____ *Preferred Name:* _____

Age: _____ *Date of Birth:* _____ *Sex: Male/Female (please circle one)*

Street Address: _____ *City:* _____ *State:* ____ *Zip Code:* _____ *How Long?* ___

Home#: _____ *Work#:* _____*Cell#:* _____*Carrier:*_____

*E-mail:*_____ *Family Dentist:* _____ *Physician:* _____

Do you want to receive text message confirmations? Yes_____ No_____ Cell #_____ Carrier_____

Person Financially Responsible: _____ *E-mail:*_____

Street Address: _____*City:* _____*State:* ___ *Zip Code:* _____*How Long?* ___

*Home#:*_____*Work#:*_____*Cell#:*_____

Place of Employment: _____ *How Long?* _____

CHIEF CONCERN: In your own words, what is the major problem with the teeth or jaws that has led to your seeking an orthodontic evaluation? _____
_____

Please circle "Yes" or "No" for each question below:			*(Leave blank for doctor's notes)*
1.	*Presently under a doctor's care?*	*Yes No*	_____
2.	*Presently taking any drugs/medicines?*	*Yes No*	_____
3.	*Any present serious medical conditions?*	*Yes No*	_____
4.	*Any past serious medical conditions?*	*Yes No*	_____
5.	*Any allergies to nickel, latex, or medications?*	*Yes No*	_____
6.	*Do teeth or jaws ever hurt?*	*Yes No*	_____
7.	*Do jaws ever make noise (click or pop)?*	*Yes No*	_____
8.	*Do jaws ever lock open or closed?*	*Yes No*	_____
9.	*Any previous orthodontic or TMJ treatment?*	*Yes No*	_____
10.	*Are there any other problems?*	*Yes No*	_____
11.	*When was last dental exam by family dentist?*	_____	_____

SIGNATURE: _____ *TODAY'S DATE:* _____

RELATION TO PATIENT: _____

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