The Practice of Dr. Nitalya Williams

Patient Information

Today's Date: _____
Patient's Name: _____ I prefer to be called: _____

Address: _____ City: _____ Zip: _____

Email Address: _____ Phone Number: _____

DOB: _____ Age: _____ Sex: _____ SSN: _____

Employer: _____Occupation: _____ How long: _____

General Dentist: _____ Date of Last Visit: _____

Spouse: _____ Phone number: _____

Address: _____ City: _____ Zip: _____

Employer: _____Occupation: _____ How long: _____

Marital status: _____ Person responsible for this account: _____

If different than above:

Billing Address: _____ City: _____ Zip: _____

Email Address: _____ Phone Number: _____

SSN: _____ DOB: _____ Age: _____ Sex: _____

Orthodontic Insurance Information

Primary Dental Insurance
Insured's Name: _____ Relation: _____ Employer: _____

DOB: _____ SSN: _____ Insurance Company: _____

Insurance Company Phone Number: _____ Member ID: _____

Secondary Dental Insurance

Insured's Name: _____ Relation: _____ Employer: _____

DOB: _____ SSN: _____ Insurance Company: _____

Insurance Company Phone Number: _____ Member ID: _____

Emergency Information

Contact Person: _____ Relation: _____ Phone: _____

Medical History

Physician's Name: _____ Phone Number: _____

Are you currently under the care of a physician: _____ Last Visit: _____

Current Physical Condition: Good ☐ Fair ☐ Poor ☐

Allergies (including drug, latex, metal, other: _____

Are you taking any medication for Osteoporosis? If so, what and for how long:

_____

List any drugs (prescription or over the counter that you are currently taking and please give a reason: _____

Are you now or could you be pregnant? Yes☐ No☐ Weeks:_____

Please answer all questions by typing checking "Yes" or "No"

Good health	Yes☐	No☐	Prolonged bleeding	Yes☐	No☐
Recent illness	Yes☐	No☐	Leukemia	Yes☐	No☐
Recent cold, cough	Yes☐	No☐	Sickle cell anemia	Yes☐	No☐
Heart or chest pain	Yes☐	No☐	Anemia	Yes☐	No☐
Heart murmur	Yes☐	No☐	Joint replacement	Yes☐	No☐
High blood pressure	Yes☐	No☐	Arthritis	Yes☐	No☐
Rheumatic fever	Yes☐	No☐	Asthma	Yes☐	No☐
Kidney disease	Yes☐	No☐	Sinus problems	Yes☐	No☐
Lung disease	Yes☐	No☐	Hay fever/Seasonal allergies	Yes☐	No☐
Diabetes	Yes☐	No☐	Nasal obstruction	Yes☐	No☐
Hepatitis	Yes☐	No☐	Severe headaches	Yes☐	No☐
Herpes (cold sores)	Yes☐	No☐	Bone disorder	Yes☐	No☐
AIDS or HIV Positive	Yes☐	No☐	Epilepsy	Yes☐	No☐
Endocrine disorder	Yes☐	No☐	Canker sores	Yes☐	No☐
Growth disorder	Yes☐	No☐	Antibiotics required for dental appointments	Yes☐	No☐
Bleeding disorder	Yes☐	No☐	Tonsils/Adenoids removed	Yes☐	No☐

Dental History

What are the main concerns you would like orthodontics to address:

_____

Have you ever had orthodontic treatment before? Yes☐ No ☐
Do you like your smile? Yes☐ No☐ Current dental health: Good☐ Fair☐ Poor☐
Do you have any history of gum or periodontal disease? Yes☐ No☐
Do you now or have you ever experienced pain/discomfort in your jaw joint (TMJ/TMD)? Yes☐ No☐
Have you ever had a serious/difficult problem associated with previous dental work? Yes☐ No☐
Have you ever had injuries to your face, mouth, teeth, or chin? Yes☐ No☐
Do you generally breath through your mouth? Awake: Yes☐ No☐ Asleep: Yes☐ No☐
Do you have any missing or extra permanent teeth? Yes☐ No☐ If yes, please explain

_____

I have read and understand the above questions. I will not hold Get It Straight Orthodontics or any staff responsible for any errors or omissions that I have made in completion of this form. If there are any changes to this history record or medical/dental status, I will so inform this practice.

Signature: _____ Date:_____