



Ashkan Ghaffari, D.D.S., M.S.D.  
100 Church Street, NE  
Vienna, VA 22180  
703.281.0466  
www.ViennaBraces.com

*Welcome to our office! We sincerely appreciate your effort in completing this extensive questionnaire. It provides information that allows delivery of the most comprehensive orthodontic care. Thank you!*

**GENERAL INFORMATION**

1. Patient's Name \_\_\_\_\_ SS# \_\_\_\_\_
2. Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_
3. Address \_\_\_\_\_ Home Phone \_\_\_\_\_
4. City/State \_\_\_\_\_ Zip \_\_\_\_\_
5. Patient's Cell Phone \_\_\_\_\_
6. Spouse's Name \_\_\_\_\_
7. Spouse's Cell Phone \_\_\_\_\_
8. Your Dentist \_\_\_\_\_ Location of Dentist (Town) \_\_\_\_\_
9. Your Physician \_\_\_\_\_ Location of Physician (Town) \_\_\_\_\_
10. Your favorite pastime \_\_\_\_\_ E-mail address \_\_\_\_\_
11. Whom may we thank for referring you to our office? \_\_\_\_\_

**MEDICAL/DENTAL HISTORY**

1. Are you under the care of a physician at present? \_\_\_\_\_
2. If so, why? \_\_\_\_\_
3. How is your general health? \_\_\_\_\_
4. Are any medications being taken? \_\_\_\_\_
5. History of: Diabetes, Rheumatic Fever, Tuberculosis, Epilepsy, Fainting, (heart, kidney, liver, blood, or bone ailments), Endocrine or growth problems (circle)
6. Are you pre-medicated prior to dental procedures? \_\_\_\_\_
7. Any **allergies**, such as to nickel, acrylic, or latex? \_\_\_\_\_
8. Do you have a communicable or infectious disease? \_\_\_\_\_ If so, please explain \_\_\_\_\_
9. Your last dental checkup was \_\_\_\_\_
10. Have you ever suffered an injury to the face or teeth? \_\_\_\_\_
11. How many teeth have been filled to repair chips or fractures? \_\_\_\_\_
12. Are you missing any permanent teeth? \_\_\_\_\_ Extra teeth? \_\_\_\_\_
13. Do you have any problems with your gum tissue involving bleeding or tooth loss? \_\_\_\_\_
14. Have you ever had a gum problem or received treatments for gum problems (seen a Periodontist)? \_\_\_\_\_

**HABITS**

1. Did you ever have a thumb or finger habit? \_\_\_\_\_
2. If so, how long has the habit been stopped? \_\_\_\_\_
3. Have you ever needed speech therapy? \_\_\_\_\_

**AIRWAY EVALUATION/JAW JOINT (TMJ)**

1. Do you suffer from allergies that obstruct nasal breathing? \_\_\_\_\_
2. Do you breathe through the mouth, or are lips often parted? \_\_\_\_\_ Are tonsil and adenoids present? \_\_\_\_\_
3. Does your jaw click or pop when eating or opening? \_\_\_\_\_ Family history of popping/clicking of TMJ? \_\_\_\_\_
4. Is there pain in the jaw? \_\_\_\_\_ Has the jaw ever been injured/traumatized? \_\_\_\_\_
5. Do you clench or grind your teeth? \_\_\_\_\_ If so, when? (day, night, constantly) \_\_\_\_\_
6. Are any of the muscles of the head and neck sore or in spasm? \_\_\_\_\_ Are you limited in jaw opening? \_\_\_\_\_

**PATIENT OUTLOOK**

1. Who noticed the need for orthodontic treatment? \_\_\_\_\_ Do you want treatment? \_\_\_\_\_
2. What would you like orthodontic treatment to accomplish? \_\_\_\_\_
3. What fears or anxieties about orthodontic treatment can we address? \_\_\_\_\_
4. Are you aware appointments may impinge on work time? \_\_\_\_\_

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office immediately of any changes in medical status. I hereby give Dr. Ghaffari and Team permission to confirm appointments using the phone number(s) I have provided, to include leaving messages

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

ADULT