



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 very much.

GENERAL INFORMATION

- Patient's Name _____ Nickname _____
- Date of Birth _____ Age _____ Sex _____
- Address _____ Home Phone _____
- City/State _____ Zip _____
- Father's Name _____ SS# _____ DOB _____
- Employer _____ Cell Phone _____
- Mother's Name _____ SS# _____ DOB _____
- Employer _____ Cell Phone _____
- Patient's School _____ Grade _____
- Patient's Dentist _____ Location of Dentist (Town) _____
- Patient's Physician _____ Location of Physician (Town) _____
- Patient's favorite hobby _____ Your e-mail address _____
- How did you hear about our office? _____ Brothers/Sisters we treat _____

MEDICAL/DENTAL HISTORY

- Is the patient under the care of a physician at present? _____ If so, why? _____
- How is the patient's general health? _____
- Are any medications being taken? _____
- History of: Diabetes, Rheumatic Fever, Tuberculosis, Epilepsy, Fainting, (heart, kidney, liver, blood, or bone ailments), Endocrine or growth problems (circle)
- Is the patient pre-medicated prior to dental procedures? _____ Any allergies, such as to nickel or latex? _____
- Does the patient have a communicable or infectious disease? _____ If so, please explain _____
- The patient's last dental checkup was _____
- Has the patient ever suffered an injury to the face or teeth? _____
- How many teeth have been filled to repair chips or fractures? _____
- Is the patient usually slow or fast in getting new teeth? _____
- To your knowledge, are there missing permanent teeth? _____ Extra teeth? _____
- To your knowledge, are there problems with the gum tissue involving bleeding or tooth loss? _____
- Has the patient ever had a gum problem or received treatments for gum problems (seen a Periodontist)? _____

HABITS

- Does the patient have a thumb or finger habit? _____
- If the patient has stopped a thumb or finger habit, at what age was the habit stopped? _____
- Does the patient attend speech therapy? _____

AIRWAY EVALUATION/JAW JOINT (TMJ)

- Does the patient suffer from allergies that obstruct nasal breathing? _____
- Does the patient breathe through the mouth, or are lips often parted? _____ Are the tonsil and adenoids present? _____
- Does the patient's jaw click or pop when eating or opening? _____ Family history of popping/clicking of TMJ? _____
- Is there pain in the jaw? _____ Has the jaw ever been injured/traumatized? _____
- Does the patient clench/grind their teeth? _____ If so, when? (day, night, constantly) _____
- Are any of the muscles of the head and neck sore or in spasm? _____ Is the patient limited in jaw opening? _____

PATIENT OUTLOOK

- Who noticed the need for orthodontic treatment? _____ Does the patient want treatment? _____
- What would you like orthodontic treatment to accomplish? _____
- What fears or anxieties about orthodontic treatment can we address? _____
- Are you aware appointments may impinge on school time? _____

GROWTH

- Is the patient adopted? _____ Do you think the patient is in a growth spurt? _____
- Based on family history, what do you predict for future overall growth? _____
- Does the patient show signs of pubertal development? _____
- For females, has the patient begun her monthly period? _____ Age began? _____

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 Parent/Guardian

Date