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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

1. Patient's Name_____ SS# _____
2. Date of Birth_____ Age_____ Sex_____
3. Address _____ Home Phone_____
4. City/State_____ Zip_____
5. Patient's Occupation_____ Work/Cell Phone_____
6. Spouse's Name_____
7. Spouse's Occupation _____ Work/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