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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_____ Nickname_____
2. Date of Birth_____ Age_____ Sex_____
3. Address_____ Home Phone_____
4. City/State_____ Zip_____
5. Father's Name_____ SS# _____ DOB _____
6. Employer_____ Cell Phone_____
7. Mother's Name_____ SS# _____ DOB _____
8. Employer_____ Cell Phone_____
9. Patient's School_____ Grade_____
10. Patient's Dentist_____ Location of Dentist (Town)_____
11. Patient's Physician_____ Location of Physician (Town)_____
12. Patient's favorite hobby_____ Your e-mail address_____
13. How did you hear about our office?_____ Brothers/Sisters we treat_____

MEDICAL/DENTAL HISTORY

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

HABITS

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

AIRWAY EVALUATION/JAW JOINT (TMJ)

1. Does the patient suffer from allergies that obstruct nasal breathing?_____
2. Does the patient breathe through the mouth, or are lips often parted?_____ Are the tonsil and adenoids present?_____
3. Does the patient's 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. Does the patient clench/grind their teeth?_____ If so, when? (day, night, constantly)_____
6. Are any of the muscles of the head and neck sore or in spasm?_____ Is the patient limited in jaw opening?_____

PATIENT OUTLOOK

1. Who noticed the need for orthodontic treatment?_____ Does the patient 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 school time?_____

GROWTH

1. Is the patient adopted?_____ Do you think the patient is in a growth spurt?_____
2. Based on family history, what do you predict for future overall growth?_____
3. Does the patient show signs of pubertal development?_____
4. 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