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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!***

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