

## **DENTAL DEPOT**ORTHODONTIC QUESTIONNARE



Welcome to our orthodontic clinic at Dental Depot.

Please provide the information requested below to help us better meet your needs.

| Chief Complaint / Reason for seeking orthodontic treatment?  |
|--|
| How long have you considered orthodontic treatment?  |
| Why have you not considered orthodontic treatment until now?   |
| Were you given a dental referral for this consultation? ☐ Yes ☐ No Who   |
| Who is your present dentist and when was the last visit to his/her office?   |
| Have you consulted previously with an orthodontist? $\square$ Yes $\square$ No   |
| Have you had orthodontic treatment? ☐ Yes ☐ No Date of services?   |
| Have you had permanent teeth removed? ☐ Yes ☐ No   |
| Have you received an injury to your face or lower jaw? ☐ Yes ☐ No  |
| If yes, describe the type of injury received and when it happened.   |
| Do you experience noises in your jaw joints when opening and closing? ☐ Yes ☐ No  Do you have temporal headaches not relieved with normal medication? ☐ Yes ☐ No |
| Have you experienced jaw locking or limited jaw opening? ☐ Yes ☐ No  |
| Do you grind your teeth at night? ☐ Yes ☐ No   |
| Any physical or medical limitations which might affect your treatments?   Yes   No   |
| Adult / guardian answer the next two questions for your child:   |
| Has your child (female) had their first menstrual cycle? ☐ Yes ☐ No What Age?  |
| Has your child (male) experienced voice change? ☐ Yes ☐ No   |
| Please describe or address any other conditions not addressed in this questionnaire.   |
|  |
|  |