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? ☐ Yes ☐ 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.

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