



# DENTAL DEPOT ORTHODONTIC QUESTIONNAIRE



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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