PATIENT FORM – Orthodontic Questionnaire

Name: _____ Age: _____ Gender: _____

Street Address: _____

City: _____ State: _____ Zipcode: _____

Email: _____ Phone: _____

If you are filling out this form on behalf of someone else, please indicate your relationship to the patient:

_____

1. Do you grind your teeth at night / day?

❑ Yes ❑ No ❑ I'm not sure

2. Are any of your teeth particularly sensitive to pressure?

❑ Yes ❑ No ❑ I'm not sure

3. Have you ever had orthodontic treatment before?

❑ Yes ❑ No

4. If you could change one thing about your smile, what would it be?

❑ Nothing, I absolutely love my smile!

❑ I have a few teeth that are slightly misaligned

❑ My bite feels off

❑ Other

5. Are you interested in straightening your teeth? *Minor corrections can be done in just a few months!*

❑ Yes ❑ No ❑ I'm not sure