TANYA VAYSMAN, DMD **CHILD**
Orthodontics & Dentofacial Orthopedics

TELL US ABOUT YOURSELF

Please complete this Questionnaire. It will assist us to become better acquainted so that we can best meet your orthodontic needs.

PATIENT AND FAMILY HISTORIES

1. Patient Name: ________________________ Sex: M F Date of Birth ______________
2. Res. Address: ____________________ City: ______________ State: ___ Zip: ______
   Tel :(______)______________ Cellular____________________________
   School:______________________ Grade:________ Is the patient adopted? Yes No
4. Name of Mother__________________ Tel :(______)____________
   Res. Address: ______________________City:________________ State: ____ Zip: __________
   Occupation: ______________ Employer:________________ BusTel:(______)______________
   Bus Address:______________________ City:________________ State:_____ Zip:__________
5. Name of Father:____________________ Tel:(______)____________
   Res. Address:______________________City:________________ State:_____ Zip:__________
   Occupation: ______________ Employer:________________ BusTel:(______)______________
   Bus Address:______________________ City:________________ State:____ Zip:__________
6. Parents are: married separated divorced widowed
7. Names & Ages of other children in your family: ______________________________
8. Who referred you to our office? ______________________________
9. Do you have insurance that provides for orthodontic care? Yes No. If Yes, please provide:
   Insurance company name______________ Address______________________________
   Policyholder________________________DOB__________SS#____________________

DENTAL HISTORY

1. Does the patient have a regular dentist? Yes No Specialist? Yes No
   Dentist's name & address: ______________________________
2. When did the patient last receive dental `care?______________________________
3. How frequently does the patient brush his/her teeth?______________ Use dental floss?__________
4. Have the patient's teeth or jaws been injured? Yes No Age at accident?__________________
   Cause of the accident? ______________________ Injuries?______________________
5. Have you been informed that the patient has any missing or extra permanent teeth? ____________ ______
6. Does patient have any jaw, joint or facial pain?______________________________
7. Does the patient have, or has the patient ever had, any of the following habits (please check):
   Lip sucking Thumb or finger sucking Lip biting Mouth breathing
   Nail biting Tongue thrusting Grinding teeth Other:__________________
8. Does the patient have any speech problems? ______________________________
9. Describe the patient's orthodontic problems as you see them: ______________________________
10. Does anyone in your family have a similar dental or facial condition:______________________
11. Has anyone else in your family received orthodontic care?______________________________
12. Has an orthodontist been consulted previously for the patient?______________________________

MEDICAL HISTORY

1. Is the patient in good health? Yes No
2. Describe any major illnesses?______________________________
3. Physicians Name and Address:______________________________
4. Has patient had : Diabetes Tuberculosis Endocrine Problems Pneumonia Anemia Asthma
   Prolonged Bleeding Heart Trouble Epilepsy Fainting/Dizziness Rheumatic Fever
   Nervous Disorders Bone Disorders Kidney Involvement Liver Involvement - Hepatitis
5. Does the patient have a tendency to any of the following: Colds Sore Throat Ear Infections Sinus Infections
6. Have the patient's tonsils / adenoids been removed? Yes No If Yes, at what age?______________
7. List any drugs or medications the patient is now taking. Indicate the reason for each:______________
8. List any of the patient's allergies or drug sensitivities:______________________________
9. Height:__________ Weight:__________ Has the patient reached puberty? Yes No
   Females: Has menstruation started? Yes No If Yes, at what age?______________________
   Males: Has his voice changed? Yes No If Yes, at what age?__________________________

Parent or Guardian's signature________________________________