

Invisalign/Orthodontic Form (Optional)

Please Tell us About Yourself	Where do you attend school or work?
	What are your hobbies/interests?
Invisalign/Orthodontic Information	Do your crooked teeth bother you?
	Are you interested in Invisalign?
	Do you have any dental concerns that affect you daily?
Dental Health	Do you feel you grind or clench your teeth?
	Have you had any problems with your TMJ (jaw joint)?
	Have you had any problems with periodontium (gums)?
Medical History	Were your Tonsils and/or Adenoids removed? If so, When?
	Do you have any Gastrointestinal Disorders?
	Any speech disorders or speech therapy?
	Do you have facial pain?
	Do you have head, neck, or jaw pain?
	Do you have any trauma to the head, neck, or mouth?
Sleep	Do you have difficulty with sleeping?
Airway	Do you snore frequently?
	Do you choke or stop breathing during sleep?
Meds	Have you taken "Bisphosphonase" or "Fosamax" for osteoporosis or cancer?