Mancini Orthodontics
Creating healthy smiles to last a lifetime
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Member American Association of Orthodontists

ORTHODONTIC SCREENING FORM

Patient Information

Name: _____ Nickname: _____ Home Phone: _____
DOB: _____ Age: _____ Cell Phone: _____
SSN: _____ Gender: _____
Email: _____ Address: _____

If Patient Under 18, Please Complete This Section for Responsible Party

Name: _____ Relationship: _____ Cell Phone: _____
DOB: _____ Marital Status: _____ Work Phone: _____
SSN: _____ Employer: _____
Email: _____ Address: _____

Dental Insurance Information

Insurance Company: _____ Phone Number: _____
Policy Holder's Name: _____ Insured's SSN: _____
Insured's DOB: _____ Policy Number: _____
Secondary Insurance: _____

General Information

School Attended: _____ Siblings & Their Date of Birth(s): _____
Interests / Hobbies: _____
Patient's Dentist: _____ Date of Last Visit: _____
Primary Concern/ Reason for Visit? _____
How did you hear of our office/ Referral: _____

For the following questions mark yes or no. The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

PATIENT PROFILE

☐**yes** ☐**no** Does patient follow directions well?
☐**yes** ☐**no** Does patient brush his/her teeth Conscientiously?
☐**yes** ☐**no** Does patient have learning disabilities or need extra help with instructions?
☐**yes** ☐**no** Is patient sensitive or self-conscious about teeth?

Allergies or reactions to any of the following:

☐**yes** ☐**no** Local anesthetics (Novocaine or Lidocaine)
☐**yes** ☐**no** Aspirin
☐**yes** ☐**no** Ibuprofen (Motrin, Advil)
☐**yes** ☐**no** Penicillin or other antibiotics
☐**yes** ☐**no** Sulfa drugs
☐**yes** ☐**no** Codeine or other narcotics
☐**yes** ☐**no** Metals (jewelry, clothing snaps)
☐**yes** ☐**no** Latex (gloves, balloons)
☐**yes** ☐**no** Vinyl
☐**yes** ☐**no** Acrylic
☐**yes** ☐**no** Animals
☐**yes** ☐**no** Foods (specify) _____
☐**yes** ☐**no** Other substances (specify) _____
☐**yes** ☐**no** Is the patient taking medication

Please name them:

Medication _____ Taken for _____
Medication _____ Taken for _____
Medication _____ Taken for _____

☐**yes** ☐**no** Does the patient currently have or ever had a substance abuse problem?
☐**yes** ☐**no** Does the patient chew or smoke tobacco?

MEDICAL HISTORY

Now or in the past, has the patient had:

☐**yes** ☐**no** Birth defects or hereditary problems?
☐**yes** ☐**no** Bone fractures, any major accidents?
☐**yes** ☐**no** Rheumatoid or arthritic conditions?
☐**yes** ☐**no** Endocrine or thyroid problems?
☐**yes** ☐**no** Kidney problems?
☐**yes** ☐**no** Diabetes?
☐**yes** ☐**no** Cancer, tumor, radiation treatment or chemotherapy?
☐**yes** ☐**no** Stomach ulcer or hyperacidity?
☐**yes** ☐**no** Polio, mononucleosis, tuberculosis or pneumonia?
☐**yes** ☐**no** Problems of the immune system?
☐**yes** ☐**no** AIDS or HIV positive?
☐**yes** ☐**no** Hepatitis, jaundice or liver problem?
☐**yes** ☐**no** Fainting spells, seizures, epilepsy or neurological problem?

☐**yes** ☐**no** Mental health disturbance or behavioral problem?
☐**yes** ☐**no** Vision, hearing, tasting or speech difficulties?
☐**yes** ☐**no** Loss of weight recently, poor appetite?
☐**yes** ☐**no** History of eating disorder (anorexia, bulimia)?
☐**yes** ☐**no** Excessive bleeding or bruising tendency, anemia or bleeding disorder?
☐**yes** ☐**no** High or low blood pressure?
☐**yes** ☐**no** Tires easily?
☐**yes** ☐**no** Chest pain, shortness of breath or swelling ankles?
☐**yes** ☐**no** Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
☐**yes** ☐**no** Skin disorder?
☐**yes** ☐**no** Does the patient eat a well-balanced diet?
☐**yes** ☐**no** Frequent headaches, colds or sore throats?
☐**yes** ☐**no** Eye, ear, nose or throat condition?
☐**yes** ☐**no** Hay fever, asthma, sinus trouble or hives?
☐**yes** ☐**no** Tonsil or adenoid conditions?
☐**yes** ☐**no** Operations?
Describe: _____
☐**yes** ☐**no** Hospitalized?
For: _____
☐**yes** ☐**no** Other physical problems or symptoms?
Describe: _____
☐**yes** ☐**no** Being treated by another health care professional?
For: _____
Date of most recent physical exam? _____
Are there any other medical conditions that we should be aware of? _____

FAMILY MEDICAL HISTORY

Do the patient's parents or siblings have any of the following health problems? If so, please explain.
Bleeding disorders _____
Diabetes _____
Arthritis _____
Metabolic disturbances _____
Severe allergies _____
Unusual dental problems _____
Jaw size imbalance _____
Any other family medical conditions that we should know about? _____

DENTAL HISTORY

Now or in the past, has the patient had:

☐**yes** ☐**no** Primary (baby) teeth removed that were not loose?
☐**yes** ☐**no** Supernumerary or "extra" teeth?
☐**yes** ☐**no** Congenitally missing teeth?
☐**yes** ☐**no** Missing teeth from extractions?
☐**yes** ☐**no** Chipped or otherwise injured primary (baby) or permanent teeth?
☐**yes** ☐**no** Teeth sensitive to hot or cold; teeth throb or ache?
☐**yes** ☐**no** Jaw fractures, cysts or mouth infections?
☐**yes** ☐**no** "Dead teeth" or root canals treated?
☐**yes** ☐**no** Bleeding gums, bad taste or mouth odor?
☐**yes** ☐**no** Periodontal "gum problems"?
☐**yes** ☐**no** Food impaction between teeth?
☐**yes** ☐**no** Thumb, finger, or sucking habit? Until what age ? _____
☐**yes** ☐**no** Abnormal swallowing habit (tongue thrusting)?
☐**yes** ☐**no** History of speech problems?
☐**yes** ☐**no** Mouth breathing habit, snoring or difficulty in breathing?
☐**yes** ☐**no** Tooth grinding, jaw clenching, clicking or locking?
☐**yes** ☐**no** Any pain in jaw or ringing in the ears?
☐**yes** ☐**no** Any pain or soreness in the muscles of the face or around the ears?
☐**yes** ☐**no** Difficulty encountered in chewing or jaw opening?
☐**yes** ☐**no** Aware of loose, broken or missing restorations (fillings)?
☐**yes** ☐**no** Any teeth irritating cheek, lip, tongue or palate?
☐**yes** ☐**no** Aware or concerned about under or over developed jaw?
☐**yes** ☐**no** "Gum Boils", frequent canker sores or cold sores?
☐**yes** ☐**no** Any relative with similar tooth or jaw relationships? Who _____
☐**yes** ☐**no** Had periodontal (gum) treatment?
☐**yes** ☐**no** Would patient object to wearing metal or clear braces should they be indicated?
☐**yes** ☐**no** Any serious trouble associated with any previous dental treatment?
☐**yes** ☐**no** Ever had a prior orthodontic examination or treatment?

I have read and understand the above questions. I will not hold my orthodontist or any member of his staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

I hereby consent to an exam provided by Dr. Mancini and any future appointments/ exams as prescribed by Dr. Mancini as part of orthodontic care.

Name: _____ Signature:_ _____ Date: _____

Relationship to Patient: