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: