



## ORTHODONTIC SCREENING FORM

### Patient Information

Name: \_\_\_\_\_ Nickname: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
SSN: \_\_\_\_\_ Gender: \_\_\_\_\_  
Email Address: \_\_\_\_\_ 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: \_\_\_\_\_ 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, no, or don't know/understand (dk/u). 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  dk/u Does patient follow directions well?  
 yes  no  dk/u Does patient brush his/her teeth conscientiously?  
 yes  no  dk/u Does patient have learning disabilities or need extra help with instructions?  
 yes  no  dk/u Is patient sensitive or self-conscious about teeth?

#### Allergies or reactions to any of the following:

- yes  no  dk/u Local anesthetics (Novocaine or Lidocaine)  
 yes  no  dk/u Aspirin  
 yes  no  dk/u Ibuprofen (Motrin, Advil)  
 yes  no  dk/u Penicillin or other antibiotics  
 yes  no  dk/u Sulfa drugs  
 yes  no  dk/u Codeine or other narcotics  
 yes  no  dk/u Metals (jewelry, clothing snaps)

- yes  no  dk/u Latex (gloves, balloons)  
 yes  no  dk/u Vinyl  
 yes  no  dk/u Acrylic  
 yes  no  dk/u Animals  
 yes  no  dk/u Foods (specify) \_\_\_\_\_  
 yes  no  dk/u Other substances (specify) \_\_\_\_\_  
 yes  no  dk/u Is the patient taking medication, nutrient supplements, herbal medications or non-prescription medicine? Please name them.

- Medication \_\_\_\_\_ Taken for \_\_\_\_\_  
Medication \_\_\_\_\_ Taken for \_\_\_\_\_  
Medication \_\_\_\_\_ Taken for \_\_\_\_\_  
 yes  no  dk/u Does the patient currently have or ever had a substance abuse problem?  
 yes  no  dk/u Does the patient chew or smoke tobacco?

#### MEDICAL HISTORY

**Now or in the past, has the patient had:**

- yes no dk/u Birth defects or hereditary problems?
- yes no dk/u Bone fractures, any major accidents?
- yes no dk/u Rheumatoid or arthritic conditions?
- yes no dk/u Endocrine or thyroid problems?
- yes no dk/u Kidney problems?
- yes no dk/u Diabetes?
- yes no dk/u Cancer, tumor, radiation treatment or chemotherapy?
- yes no dk/u Stomach ulcer or hyperacidity?
- yes no dk/u Polio, mononucleosis, tuberculosis or pneumonia?
- yes no dk/u Problems of the immune system?
- yes no dk/u AIDS or HIV positive?
- yes no dk/u Hepatitis, jaundice or liver problem?
- yes no dk/u Fainting spells, seizures, epilepsy or neurological problem?
- yes no dk/u Mental health disturbance or behavioral problem?
- yes no dk/u Vision, hearing, tasting or speech difficulties?
- yes no dk/u Loss of weight recently, poor appetite?
- yes no dk/u History of eating disorder (anorexia, bulimia)?
- yes no dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?
- yes no dk/u High or low blood pressure?
- yes no dk/u Tires easily?
- yes no dk/u Chest pain, shortness of breath or swelling ankles?
- yes no dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
- yes no dk/u Skin disorder?
- yes no dk/u Does the patient eat a well-balanced diet?
- yes no dk/u Frequent headaches, colds or sore throats?
- yes no dk/u Eye, ear, nose or throat condition?
- yes no dk/u Hay fever, asthma, sinus trouble or hives?
- yes no dk/u Tonsil or adenoid conditions?
- yes no dk/u Operations?  
Describe: \_\_\_\_\_
- yes no dk/u Hospitalized?  
For: \_\_\_\_\_
- yes no dk/u Other physical problems or symptoms?  
Describe: \_\_\_\_\_
- yes no dk/u 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? \_\_\_\_\_

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

**FAMILY MEDICAL HISTORY**

I authorize Dr Mancini to assess \_\_\_\_\_ for the possibility of orthodontic treatment. I understand that this is not a contract to any treatment and a final determination of treatment will be made after the case has been fully diagnosed with appropriate diagnostic records. 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.

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_