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

# ORTHODONTIC MEDICAL HISTORY FORM

## Patient Information

Name: _____ Nickname: _____ Home Phone: _____
DOB: _____ Age: _____ Cell Phone: _____
Address: _____ Gender: _____ Is patient currently pregnant? ☐**yes** ☐**no**
Email: _____ Permission to leave detailed voicemails? ☐**yes** ☐**no**

## If Patient Under 18, Please Complete This Section

Mother: _____ Marital Status: _____
DOB: _____ Employer: _____
Address: _____ Phone: _____ Detailed voicemails? ☐**yes** ☐**no**
Email: _____ Text/Email: _____ For appointment reminders: ☐**yes** ☐**no**

Father: _____ Marital Status: _____
DOB: _____ Employer: _____
Address: _____ Phone: _____ Detailed voicemails? ☐**yes** ☐**no**
Email: _____ Text/Email: _____ For appointment reminders: ☐**yes** ☐**no**

Guardian: _____ Relation: _____
DOB: _____ Employer: _____
Address: _____ Phone: _____ Detailed voicemails? ☐**yes** ☐**no**
Email: _____ Text/Email: _____ For appointment reminders: ☐**yes** ☐**no**

## Dental Insurance Information

Insurance Company: _____ Phone Number: _____
Policyholder Name: _____ Policyholder SSN: _____
Policyholder DOB: _____ Policy Number: _____

## 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.**

### 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** Aspirin
☐**yes** ☐**no** Ibuprofen (Motrin, Advil)
☐**yes** ☐**no** Penicillin or other antibiotics
☐**yes** ☐**no** Metals (jewelry, clothing snaps)
☐**yes** ☐**no** Latex (balloons, rubber bands)
☐**yes** ☐**no** Vinyl
☐**yes** ☐**no** Acrylic
☐**yes** ☐**no** Foods (specify) _____
☐**yes** ☐**no** Does the patient chew, smoke/vape?
☐**yes** ☐**no** Has patient ever taken medication for Osteoporosis? If so, what? _____

☐**yes** ☐**no** Is the patient taking medication
If yes, please name them:

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

## 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** History of eating disorder (anorexia, bulimia)?
☐**yes** ☐**no** Excessive bleeding or bruising tendency, anemia or bleeding disorder?
☐**yes** ☐**no** High or low blood pressure? High ☐ Low ☐
☐**yes** ☐**no** Chest pain, shortness of breath or swelling ankles?
☐**yes** ☐**no** Cardiovascular problem
☐**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** Being treated by another health care professional?
For: _____

Date of most recent physical exam? _____

## DENTAL HISTORY

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

☐**yes** ☐**no** Supernumerary or "extra" teeth?
☐**yes** ☐**no** Congenitally missing 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** Had periodontal (gum) treatment?
☐**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 in chewing or jaw opening?
☐**yes** ☐**no** Any relative with similar tooth or jaw relationships? Who? _____
☐**yes** ☐**no** Ever had a prior orthodontic examination or treatment?

## FAMILY MEDICAL HISTORY

Does anyone in your family have:
Severe Allergies: _____
Unusual dental problems: _____
Jaw Imbalance: _____
Any other family medical condition we should know about:
_____
_____

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: _____

**Acknowledgement of Receipt/Review of Notice of Privacy Practices and OCR Notice of Non-Discrimination:**

I acknowledge receipt/review of the Notice of Privacy Practices and OCR Notice of Non-Discrimination of Mancini Orthodontics, Kevin J. Mancini, DMD, PA. This was provided with the initial, new patient paperwork and is also available at www.ManciniOrthodontics.com.

Name: _____ Signature: _____ Date: _____