CHARLES A. MANILLA, D.D.S., M.S., INC.

SPECIALIST IN ORTHODONTICS
CHILDREN AND ADULTS
CLEAR BRACES – INVISALIGN

347 PARK AVENUE
HAMILTON, OHIO 45013
(513) 737-6442
FAX (513) 737-3501

7370 KINGSGATE WAY
WEST CHESTER, OHIO 45069
(513) 779-0555
FAX (513) 779-0556

PATIENT'S CLINICAL HISTORY/PERSONAL INFORMATION

(Please complete in ink.)

Name _____ Age _____ Sex _____ Date of Birth_____
Last First M.I.

Home Address _____ Tel. # ( ) _____
Street City Zip

Employed by _____ Occupation _____ Position _____

Employer Address _____ Work Tel. # ( )_____
Street City Zip

Best Telephone Number to call for appointments **(During Business Hours)**_____

Best Fax # _____ Best Cell Phone # _____ Best E-Mail Address _____

Social Security Number of Patient **(for accounting purposes only)** _____

Marital Status:

❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Remarried

Husband/Wife Name _____ Date of Birth _____
Last First M.I.

Employed by _____ Occupation _____ Position _____

Employer Address _____ Work Tel. # ( )_____
Street City Zip

Patient's Family Dentist _____

Patient's Family Physician _____

Whom may we thank for referring you to our office?_____

Do you have Orthodontic Insurance? ____ Yes ____ No Name of Insurance Company _____

Do you have Medical Insurance? ____ Yes ____ No Name of Insurance Company _____

If responsible party is other than the patient, please give information: ❑ Not Applicable

Name _____ S.S. # _____ Relationship to Patient _____

Address _____ Tel. # ( ) _____
Street City Zip

Does responsible party have Orthodontic Insurance? ____ Yes ____ No Name of Insurance Company _____

Does responsible party have Medical Insurance? ____ Yes ____ No Name of Insurance Company _____

MEDICAL HISTORY

Have you had or do you have any of the following?

	Yes	No		Yes	No
Rheumatic Fever	❑	❑	Persistent Headaches	❑	❑
Heart Murmur	❑	❑	Neck Pains	❑	❑
High Blood Pressure	❑	❑	Nerve or Brain Disease	❑	❑
Heart Attack/Stroke	❑	❑	Migraine	❑	❑
Blood Vessel Disease	❑	❑	Epilepsy	❑	❑
Blood Disorder	❑	❑	Mental Health Problems	❑	❑
AIDS/HIV Infection	❑	❑	Bone Disorders	❑	❑
Hepatitis	❑	❑	Arthritis (Any Type)	❑	❑
Diabetes	❑	❑	Sleep Apnea	❑	❑
Ulcers	❑	❑	Ear Disorder	❑	❑
Herpes (Any Type)	❑	❑	Sinus Infection	❑	❑
Psoriasis	❑	❑	Swollen Glands	❑	❑
Cancer	❑	❑	Allergies (specify: _____)	❑	❑

Comments _____

Please list any other significant information about your medical history:

_____

_____

Yes	No	
❑	❑	Are you under a physician's care at present? If yes, reason_____
❑	❑	Are you presently, or have you ever been, under the care of a psychiatrist of psychologist?
		If yes, describe _____
❑	❑	Are you currently taking any medication? If yes, describe _____
❑	❑	Are you allergic to any medication? (eg: aspirin, penicillin, etc.) If yes, _____
❑	❑	Have you ever had any general anesthesia? If yes, when_____

FEMALE PATIENTS

Yes	No	
❑	❑	Do you have regular menstrual cycles?
❑	❑	Have you experienced menopause?
❑	❑	Has anyone in your family had osteoporosis?
❑	❑	Is there a possibility that you could be pregnant?

DENTAL HISTORY

Yes	No	
❑	❑	Do any of your teeth hurt? If yes, ❑ upper right ❑ upper left ❑ lower right ❑ lower left
❑	❑	Have any wisdom teeth been removed? How many? _____
❑	❑	Have you ever had treatment for a periodontal disease (gum disease)? If yes, describe _____
❑	❑	Have you ever had any previous orthodontic treatment (braces)? If yes, when _____
		If yes, doctor's name and address _____
❑	❑	Have there been any injuries to your mouth or teeth? If yes, describe_____
❑	❑	Have you ever had any injury in the head and neck area? If yes, describe _____
❑	❑	Have you ever fallen and bumped your chin, or received a blow to your jaws? If yes, describe _____
❑	❑	Have you ever had any surgery in the head and neck area? If yes, describe _____
❑	❑	Do you clench or grind your teeth? If yes, ❑ while sleeping ❑ under stress ❑ other _____
❑	❑	Do your jaw muscles ever feel tired? If yes, when _____
❑	❑	Do you ever notice soreness, tightness or pain in the muscles around the jaws and face? If yes, describe _____
		_____
❑	❑	Does it hurt to chew? If yes, where does it hurt? _____

Yes No

❑ ❑ Do you hear clicking (popping) or grating sounds in your jaw joints? If yes, please describe:

	Right	Left	Since when?	During what activity?
❑ Clicking:	❑	❑	_____	_____
❑ grating:	❑	❑	_____	_____

Did these joint sounds begin gradually or suddenly? ❑ gradually ❑ suddenly

❑ ❑ Was there some specific event that started the joint sounds? If yes, describe _____

❑ ❑ Have you ever experienced difficulty in opening or closing your jaws? If yes, describe _____

❑ ❑ Have your jaws ever "locked" closed? If yes, describe _____

❑ ❑ Have your jaws ever "locked" wide open? If yes, describe _____

❑ ❑ Do you have pain in your jaw joints? If yes, ❑ right ❑ left Since when? _____

Did your pain start gradually or suddenly? ❑ gradually ❑ suddenly

During what activity? _____ Describe the nature of the pain _____

What increases the pain? _____ What decreases the pain? _____

Do you have any of the following habits?

	Yes	/	No		Yes	/	No
Finger/Thumbsucking	❑		❑	Smoking	❑		❑
Lip Biting	❑		❑	Mouth Breathing	❑		❑
Nail Biting	❑		❑	Tongue-Thrust	❑		❑
Gum Chewing	❑		❑	Other	❑		❑
Ice Chewing	❑		❑	(Specify) _____			

NOTE: Smoking and chewing tobacco products suppress the body's ability to fight disease and increases susceptibility to advanced periodontal problems and oral cancer.

Please describe why you sought this consultation_____

Yes No

❑ ❑ Have you ever been treated for this problem before? If yes, please describe the diagnosis and treatment. _____

_____

Were you satisfied with the results? ❑ Yes ❑ No

❑ ❑ Has any other member of the family had orthodontic treatment?

❑ ❑ Has any other member of the family been a patient in this office? ❑ Yes ❑ No

Name_____

We recognize that patients sometimes have specific concerns that may not be addressed by the questions in this Clinical History Form. Please feel free to include any other information regarding your clinical history, or any other concerns that you may have, in the space below. If necessary, please use the back page of this form.

_____

_____

I, the undersigned, certify that I have read and understand the above medical and dental information, have reviewed it, and find it accurate. If there are any later changes to my clinical history, I recognize that it is my responsibility to inform this office. I also give my permission for a clinical examination. This office reserves the right to verify the credit status of potential patients and/or parents prior to extending credit for treatment fees.

_____ _____

(Patient's Signature) (Date)

Doctor's Notes _____

_____

_____

_____

_____

_____ _____

(Doctor's Signature) (Date)

ADDITIONAL CONCERNS: _____