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/Family Information

(Please complete in ink.)

Name ______________________________ Age _______ Sex _______ Date of Birth __________
Last First M.I.

Home Address ______________________________ Tel. # ( ) __________
Street City Zip

School ______________________ Grade __________ S.S.# of Patient __________

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

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

Father's Name ______________________________ Father's S.S.# __________
Last First M.I. **(For accounting purposes only)**

Date of Birth ______________

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Remarried

Home Address ______________________________ Tel. # ( ) __________

Employed by ______________________ Occupation __________ Position __________

Office Address ______________________________ Work Tel. # ( ) __________

Does Father have Orthodontic Insurance? ____ Yes ____ No Name of Insurance Company __________

Does Father have Medical Insurance? ____ Yes ____ No Name of Insurance Company __________

Mother's Name ______________________________ Mother's S.S.# __________
Last First M.I. **(For accounting purposes only)**

Date of Birth ______________

Marital Status: ❑ Single ❑ Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Remarried

Home Address ______________________________ Tel. # ( ) __________

Employed by ______________________ Occupation __________ Position __________

Office Address ______________________________ Work Tel. # ( ) __________

Does Mother have Orthodontic Insurance? ____ Yes ____ No Name of Insurance Company __________

Does Mother have Medical Insurance? ____ Yes ____ No Name of Insurance Company __________

Patient's Family Dentist ______________________________

Patient's Family Physician ______________________________

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

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

Name ______________________ S.S. # __________ Relationship to Patient __________

Address ______________________ Date of Birth __________ Tel. # ( ) __________

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

Has patient had or does patient 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 the patient's medical history:

____

____

Yes	No	
❏	❏	Is patient under a physician's care at present? If yes, reason ____
❏	❏	Is patient presently, or has patient ever been, under the care of a psychiatrist of psychologist? If yes, describe ____
❏	❏	Is patient currently taking any medication? If yes, describe ____
❏	❏	Is patient allergic to any medication? (eg: aspirin, penicillin, etc.) If yes, ____
❏	❏	Has patient ever had any general anesthesia? If yes, when ____

DENTAL HISTORY

Yes	No	
❏	❏	Do any of the patient's teeth hurt? If yes, ❏ upper right ❏ upper left ❏ lower right ❏ lower left
❏	❏	Have any wisdom teeth been removed? How many? ____
❏	❏	Has the patient had treatment for a periodontal disease (gum disease)? If yes, describe ____________________
❏	❏	Have there been any injuries to the patient's mouth or teeth? If yes, describe ____________________
❏	❏	Has the patient ever had any injury in the head and neck area? If yes, describe ____________________
❏	❏	Has the patient ever fallen and bumped their chin, or received a blow to their jaws? If yes, describe ____________________
❏	❏	Has the patient ever had any surgery in the head and neck area? If yes, describe ____________________
❏	❏	Does the patient clench or grind their teeth? If yes, ❏ while sleeping ❏ under stress ❏ other ____________________
❏	❏	Does the patient's jaw muscles ever feel tired? If yes, when ____
❏	❏	Does the patient 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? ____
❏	❏	Does the patient hear clicking (popping) or grating sounds in their 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

Yes	No	
❏	❏	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 ____

Yes	No	
❑	❑	Does the patient have pain in their jaw joints? If yes, ❑ right ❑ left Since when?______________________________
		Did their pain start gradually or suddenly? ❑ gradually ❑ suddenly
		During what activity? ____________________________________ Describe the nature of the pain _____________________
		What increases the pain? ________________________________ What decreases the pain? _________________________

Does the patient have any of the following habits?

	Yes	No		Yes	No	
Finger/Thumbsucking	❑	❑	Mouth Breathing	❑	❑	
Lip Biting	❑	❑	Tongue-Thrust	❑	❑	
Nail Biting	❑	❑	Tonsils Removed	❑	❑	Date_____________
Gum Chewing	❑	❑	Adenoids Removed	❑	❑	Date_____________
Ice Chewing	❑	❑	Other	❑	❑	

(Specify) ____

GROWTH AND DEVELOPMENT

Yes	No	
❑	❑	Has the patient reached adolescent growth? ____
❑	❑	Girls - Has monthly cycle started yet? If so, when? ______________________________________
❑	❑	Boys - Has voice changed yet? If so, when ____
❑	❑	Is the patient adopted? Does the patient know? ❑ Yes ❑ No
❑	❑	Are there any learning disabilities? If yes, explain______________________________________
		Patient's present height ________________________________ Expected height of patient ___________________________
		Father's Height ___________________________________ Mother's Height? _________________________________
❑	❑	Are there other children in the family? ____
		Names and ages ____
❑	❑	Has any other member of the family had orthodontic treatment? ❑ Yes ❑ No
		Were you satisfied with the results? ❑ Yes ❑ No
❑	❑	Has any other member of the family been a patient in this office? ❑ Yes ❑ No
		Name____

Please describe why you sought this consultation____

ORTHODONTIC INFORMATION

1. Has patient ever had orthodontic treatment (braces)? ❑ Yes ❑ No
   If yes, when and by whom____
2. Has patient ever had an orthodontic examination, evaluation, conference or consultation? ❑ Yes ❑ No
   If yes, when and by whom____
3. Has patient ever had orthodontic records, such as x-rays, study models or photographs? ❑ Yes ❑ No
   If yes, when and by whom____
4. Do you feel patient's teeth can be straighter? ❑ Yes ❑ No
5. Do you feel patient's occlusion (bite) needs to be improved? ❑ Yes ❑ No
6. Has patient ever been told to see an orthodontist? ❑ Yes ❑ No
   If yes, when and by whom____

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.

____ _________________________________
(Signature of Responsible Adult) (Date)

____ _________________________________
(Doctor's Signature) (Date)

ADDITIONAL CONCERNS: ____