Clemente ORTHODONTICS

DR. NICOLE CLEMENTE · DR. MICHAEL CLEMENTE · DR. MARISSA CLEMENTE

603 South Route 304
New City, NY 10956
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www.clementeorthodontics.com

60 West Ridgewood Ave
Ridgewood, NJ 07450
(201) 447-2888
clementerw@aol.com

Adult Medical History Form

General Information

Today's Date: _____

Patient's Name: _____ Date of Birth: _____

Age: _____ Male: _____ Female: _____ Social Security Number: _____

Home Address: _____

Home Phone #: _____ Cell Phone #: _____ Cell Carrier Service: _____

Would you like to receive text confirmation? ( ) Y ( ) N

E-mail Address: _____

Employer: _____ Occupation: _____

Business Address: _____

Work #: _____

MARITAL STATUS: ( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) Other

Spouse's Name: _____ Cell Phone #: _____

Address: _____

Employer: _____ Occupation: _____

Date of Birth: _____ Social Security Number: _____

NAMES & AGES OF CHILDREN: _____

DENTIST INFORMATION

Family Dentist: _____

Last Visit Date: _____ Office Phone #: _____

Address: _____

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Who May We Thank for Referring You?

Please check all that apply.

□ Your Dentist	□ Friends	□ Google
□ Other Dentist	□ Moms' Group	□ Facebook
□ Sibling	□ School	□ Instagram
□ Other Family Member	□ Our Website	□ Other Social Media
□ Former Patient	□ Invisalign Website	□ Print Ads

What is your main reason for choosing us?

_____

_____

_____

_____

Dental Insurance Information

Primary Insurance

Insurance Co. Name: _____

Group #: _____ Insurance Co. Phone #: _____

Insurance Co. Address: _____

Insured's Name: _____ Relationship: _____

Insured's Birthdate: _____ Insured's Social Security #: _____

Insured's Employer: _____

Secondary Insurance

Insurance Co. Name: _____

Group #: _____ Insurance Co. Phone #: _____

Insurance Co. Address: _____

Insured's Name: _____ Relationship: _____

Insured's Birthdate: _____ Insured's Social Security #: _____

Insured's Employer: _____

Medical History

It is extremely imperative for your benefit, and others that you fill out this form completely. Thank you.

Physician: _____

Last Visit Date: _____ **Office Phone #:** _____

Address: _____

Do Any Of The Following Apply To You?

( ) Y ( ) N Anemia
( ) Y ( ) N ( ) Artificial / ( ) Replacement Joints
( ) Y ( ) N ( ) High / ( ) Low Blood Pressure
( ) Y ( ) N Blood transfusion
( ) Y ( ) N ( ) Cancer / ( ) Chemotherapy
( ) Y ( ) N Diabetes (Type: _____)
( ) Y ( ) N Drug / Alcohol Abuse
( ) Y ( ) N Epilepsy / Seizures / Fainting Spells
( ) Y ( ) N Fever Blisters / Herpes
( ) Y ( ) N Glaucoma
( ) Y ( ) N Hemophilia / Abnormal Bleeding
( ) Y ( ) N Hepatitis (Type: _____)
( ) Y ( ) N ( ) HIV+ / ( ) AIDS
( ) Y ( ) N Arthritis
( ) Y ( ) N Kidney Problems
( ) Y ( ) N Psychiatric Problems
( ) Y ( ) N Severe / Frequent Headaches
( ) Y ( ) N Sexually Transmitted Disease
( ) Y ( ) N Shingles
( ) Y ( ) N Smoking
( ) Y ( ) N ( ) Ulcers / ( ) Colitis
( ) Y ( ) N ( ) Cleft Lip / ( ) Cleft Palate

Cardiac Conditions:

( ) Y ( ) N ( ) Congenital Heart Defects / ( ) Artificial Valves

( ) Y ( ) N Heart Murmur

( ) Y ( ) N ( ) Heart Surgery / ( ) Pacemaker

( ) Y ( ) N ( ) Heart Attack / ( ) Stroke

( ) Y ( ) N Mitral Valve Prolapse

( ) Y ( ) N ( ) Rheumatic / ( ) Scarlet Fever

Respiratory Conditions:

( ) Y ( ) N Asthma

( ) Y ( ) N Allergies (Latex / Medications / Food) Please specify: _____

( ) Y ( ) N Emphysema ( ) Y ( ) N Sinus Problems

( ) Y ( ) N Tuberculosis

Have you been hospitalized for any reason? ( ) Y ( ) N

If yes, please describe: _____

Are you currently under care of a physician? ( ) Y ( ) N

If yes, please describe: _____

Are you currently taking any medication(s) prescribed by a physician or dentist? ( ) Y ( ) N

If yes, please describe: _____

To help us serve you better, are there any neurological/psychological/emotional/developmental conditions (Hypersensitivity, ADHD, ADD, Autism, etc…) that you would like us to know about? ( ) Y ( ) N

If yes, please describe:

_____

_____

HAVE YOU EVER TAKEN ANY OF THE BISPHOSPHONATE PREPARATIONS?

ORAL

( ) Y ( ) N Fosamax

( ) Y ( ) N Skelid

( ) Y ( ) N Actonel

( ) Y ( ) N Didronel

( ) Y ( ) N Boniva

IV

( ) Y ( ) N Aredia

( ) Y ( ) N Zometa

DO YOU HAVE ANY OF THE FOLLOWING CO-EXISTING RISK FACTORS?

( ) Y ( ) N Diabetes

( ) Y ( ) N Smoking

( ) Y ( ) N Current Chemo-Therapy

( ) Y ( ) N Alcohol

( ) Y ( ) N Long term Steroid Use

List & discuss any medical problems: _____
_____
_____

INFORMED CONSENT FOR BISPHOSPHONATE THERAPY

Bisphosphonates are a class of compounds used for the treatment of many different medical conditions.

These compounds localize to bone and inhibit osteoclast- mediated bone resorption.

Since bisphosphonates are not metabolized, high concentrations are maintained within the bone for a long time.

Successful orthodontic treatment depends on osteoclastic activity to allow tooth movement. Inhibition of tooth movement occurs to a greater degree with high IV doses than lower oral doses.

The most serious dental side effect of bisphosphonate treatment (particularly when it is administered intravenously) is *Osteonecrosis* of the mandible or maxilla represented by exposed non-healing bone. Other related complications include decreased bone healing and inhibition of orthodontic tooth movement.

By my signature below, I affirm that I have read this consent form, and have had the opportunity to ask questions. Also, unfamiliar terms have been explained to me.

Patient Name: _____

Signature: _____ Date: _____

Dental History

Have you ever experienced pain / discomfort in the jaw joint (TMJ)? ( ) Y ( ) N
If YES, are you currently being treated? _____

Have you ever experienced tenderness / pain in your jaw joint? ( ) Y ( ) N

Have you ever experienced locking? (Either open lock or closed lock) ( ) Y ( )N

Do you clench / grind teeth? ( ) Y ( ) N

Any limitations in the range of movement? ( ) Y ( ) N

Have there been any injuries to the: ( ) Face ( ) Mouth ( ) Teeth ( ) Chin
If YES, please explain:_____

Have you ever been diagnosed with Gingival (Gum) Disorder? ( ) Y ( ) N

Do you need to be pre-medicated with an antibiotic prior to invasive dental procedures that will cause bleeding because of a heart problem? ( ) Y ( ) N

Orthodontic History

Have you had previous orthodontic treatment? ( ) Y ( ) N
If YES, please explain: _____

Have you consulted another orthodontist? ( ) Y ( ) N

Do you have any other family member(s) that are currently being treated orthodontically? ( ) Y ( ) N
If YES, please list and explain: _____

What are your concerns / reasons for desiring orthodontic treatment? _____
_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my status. **I authorize the dental staff to perform any necessary dental services that I may need during the diagnosis and treatment with my informed consent.**

_____ _____

Signature Date

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

Dentists participating in the Give Kids a Smile® program may be required by applicable federal and state law to maintain the privacy of your health information. Protection of patient privacy is important to participants in the Give Kids a Smile® Program. This notice summarizes the privacy practices that will be followed by participants in the Give Kids a Smile® Program, and your rights concerning your health information. This Notice will apply to health information collected in connection with the Give Kids a Smile® program to be held on [insert date], and will remain in effect until we replace it.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment. For example, we may use or disclose your health information to another dentist, physician or other health care provider providing treatment to you.

Your Authorization: Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person involved in your treatment to the extent necessary to help with your healthcare.

Persons Involved In Care: We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. Contact us using the information listed at the end of the Notice for assistance in reaching the dentist or facility holding your health information.

Disclosure Accounting: You may have the right to receive a list of instances in which your health information was disclosed for purposes other than treatment or certain other activities for the last 6 years, but not before April 14, 2003.

Restriction: You may request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You may request that we communicate with you about your health information by alternative means or to alternative locations. We may agree to reasonable requests.

Amendment: You may request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice.

You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact: _____
Telephone: _____ Fax: _____
E-mail: _____
Address: _____

This form does not constitute legal advice and covers only federal law.

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ACKNOWLEDGEMENT OF RECEIPT: NOTICE OF PRIVACY PRACTICES

You May Refuse To Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

Please Print Name: _____

Signature: _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgement could not be obtained because:

( ) Individual refused to sign
( ) Communications barriers prohibited obtaining the acknowledgement
( ) An emergency situation prevented us from obtaining acknowledgement.
( ) Other (Please Specify):

_____
_____
_____
_____