

CLEMENTE ORTHODONTICS, P.A

DR. NICOLE CLEMENTE ♦ DR. MARISSA CLEMENTE ♦ DR. MICHAEL CLEMENTE

603 SOUTH ROUTE 304 NEW CITY, NY 10956 * PHONE: (845-638-6646) * E-MAIL: clementenc@optonline.net
www.clementeorthodontics.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 #: _____

E-mail Address: _____ Would you like to receive email confirmation? Y N

Employer: _____ Occupation: _____

Business Address: _____

Work # _____

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

Spouse's name: _____ Cell Phone # _____

Employer: _____ Occupation: _____

Business Address: _____

Work # _____

NAMES & AGES OF CHILDREN: _____

Names of other family members seen by us: _____

WHO MAY WE THANK FOR REFERRING YOU? _____

Family Dentist: _____

Last Visit Date: _____ Office Phone #: _____

Address: _____

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

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 (child's) status. ***I authorize the dental staff to perform any necessary dental services that I / my child may need during the diagnosis and treatment with my informed consent.***

Signature

Date