CLEMENTE ORTHODONTICS, P.A

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

60 W. RIDGEWOOD AVENUE RIDGEWOOD, NJ 07450 ⚜ PHONE: (201-447-2888) ⚜ E-MAIL: clementerw@aol.com
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 Artificial / Replacement Joints
Y N Arthritis
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 High / Low Blood Pressure
Y N HIV+ / AIDS
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, Austism, Down Syndrome, 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 Actonel

Y N Boniva

Y N Skelid

Y N Didronel

IV

Y N Aredia

Y N Zometa

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

Y N Diabetes

Y N Current Chemo-Therapy

Y N Long term Steroid Use

Y N Smoking

Y N Alcohol

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?
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**