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Today's Date: _____

Adult New Patient Form
General Information

Patient's Name: _____

Date of Birth: _____ Age: _____ Pronouns or Gender: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Email Address: _____

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

Would you like to receive confirmation by: Email Text

Employer: _____ Occupation: _____

Business Address: _____ Work Phone: _____

Marital Status: Married Divorced Single Widowed Other

Spouse's Name: _____ Cell Phone #: _____

Employer: _____ Occupation: _____

Names and Ages of Children: _____

Names of other family members seen by us: _____

Who may we thank for referring you? _____

How did you hear about our office? Please check all that apply:

- Dentist
- Family Member
- Friends
- Google
- Facebook
- Invisalign Website
- School
- Print Ads
- Commercial
- Our Website
- Instagram
- Other: _____

Medical History

It is extremely important that you fill out this form completely. Thank you.

Physician: _____

Last Visit: _____

Address: _____

Office Phone: _____

Is your general health good at this time? _____

Do any of the following apply to you? Please check all that apply.

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

Cardiac Conditions:

- | Y | N | | Y | N | |
|--------------------------|--------------------------|--|--------------------------|--------------------------|---------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Congenital Heart Defects / Artificial Valves | <input type="checkbox"/> | <input type="checkbox"/> | Heart Attack / Stroke |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Murmur | <input type="checkbox"/> | <input type="checkbox"/> | Mitral Valve Prolapse |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart Surgery / Pacemaker | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic / Scarlet Fever |

Respiratory Conditions:

- | Y | N | | Y | N | |
|--------------------------|--------------------------|-----------|--------------------------|--------------------------|----------------|
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma | <input type="checkbox"/> | <input type="checkbox"/> | Sinus Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Emphysema | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis |

Medical History

Have you been hospitalized for any reason?

YES

NO

If yes, please describe: _____

Are you currently under the care of a physician?

YES

NO

If yes, please describe: _____

Do you have any allergies (Latex/Medication/Food)? Please Specify.

Are you currently taking any medications prescribed by a doctor or dentist?

YES

NO

If yes, please describe:

Have you previously or are you currently taking any Bisphosphonates ?

YES

NO

(For Osteoporosis, Bone Cancer, etc)

To help us serve you better, are there any neurological /psychological/emotional/developmental conditions

(ADHD, ADD, Autism, Hypersensitivity, etc.) that you would like us to know about?

YES

NO

If yes, please describe: _____

Do you have any of the following co-existing risk factors?

Y

N

Diabetes

Y

N

Smoking

Current Chemotherapy

Alcohol

Long-term Steroid Use

List and discuss any medical problems:

Please continue to the next page.....

Dental History

Family Dentist: _____ Last Visit: _____

Have you ever experienced pain/discomfort in the jaw joint (TMJ)? YES NO

If yes, are you currently being treated? _____

Have you ever experienced locking? YES NO

Any limitations in range of motion? YES NO

Have there been any injuries to: FACE MOUTH TEETH CHIN

If yes, please explain: _____

Have you ever been diagnosed with a Gum Disorder? YES NO

Do you need to be premedicated prior to invasive dental procedures because of a heart problem?
 YES NO

Orthodontic History

Have you had previous orthodontic treatment? YES NO

If yes, please explain: _____

Have you consulted another orthodontist? YES NO

Are any family member(s) currently being treated orthodontically? YES NO

If yes, please list and explain:

What aspect of Orthodontic treatment are you most concerned with?

Cost Discomfort Time Quality None

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 diagnosis and treatment with my informed consent.**

Patient Name: _____

Signature: _____

Date: _____

Dental Insurance Information

Primary Insurance

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone #: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Employer: _____

Policy Holder's ID # / SSN: _____ Group #: _____

Relationship to Patient: _____

and
snap a picture of the FRONT & BACK of your dental insurance card!



Secondary Insurance

Insurance Company Name: _____

Insurance Company Address: _____

Insurance Company Phone #: _____

Policy Holder's Name: _____ Policy Holder's DOB: _____

Policy Holder's Employer: _____

Policy Holder's ID # / SSN: _____ Group #: _____

Relationship to Patient: _____

and
snap a picture of the FRONT & BACK of your dental insurance card!



NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

UNDERSTANDING YOUR HEALTH INFORMATION

Each time you visit our office, we make a record of your visit in order to manage the care you receive. We understand that the medical information that is recorded about you and your health is personal. The confidentiality and privacy of your health information is also protected under both state and federal law.

This Notice of Privacy Practices describes how this office may use and disclose your information and the rights that you have regarding your health information.

TO READ THE ENTIRE NOTICE OF OUR PRIVACY PRACTICES, PLEASE VISIT OUR WEBSITE AT
CLEMENTEORTHODONTICS.COM

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

“You May Refuse to Sign This Acknowledgment”

I have received a copy of this office’s Notice of Privacy Practices.

Patient Name: _____

Signature: _____ Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices but acknowledgment 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): _____