Clemente ORTHODONTICS

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Today's Date: _____

Child New Patient Form

Patient Information

Patient's Name: _____

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

Patient's School / Grade: _____

Names and Ages of Siblings: _____

Names of other family members seen by us: _____

Responsible Party Information

Marital Status: ☐Married ☐ Divorced ☐Single ☐ Widowed ☐Other

Parent/Guardian's Name: _____ Date of Birth: _____

Relationship to Patient: _____ Email Address: _____

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

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

Employer: _____ Occupation: _____

Parent/Guardian's Name: _____ Date of Birth: _____

Relationship to Patient: _____ Email Address: _____

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

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

Employer: _____ Occupation: _____

Who may we thank for referring you? _____

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

☐ Dentist ☐ School ☐ Family Member ☐ Friends ☐ Facebook ☐Invisalign Website
☐ Google ☐ 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	
☐	☐	Anemia	☐	☐	Hepatitis (Type: _____)
☐	☐	Artificial / Replacement Joints	☐	☐	HIV + / AIDS
☐	☐	High / Low Blood Pressure (Type: _____)	☐	☐	Arthritis
☐	☐	Blood Transfusion	☐	☐	Kidney Disease
☐	☐	Cancer / Chemotherapy	☐	☐	Psychiatric Disorders
☐	☐	Diabetes (Type: _____)	☐	☐	Severe / Frequent Headaches
☐	☐	Drug / Alcohol Abuse	☐	☐	Sexually Transmitted Disease
☐	☐	Epilepsy / Seizures / Fainting Spells	☐	☐	Shingles
☐	☐	Fever Blisters / Herpes	☐	☐	Smoking
☐	☐	Glaucoma	☐	☐	Ulcers / Colitis
☐	☐	Hemophilia / Abnormal Bleeding	☐	☐	Cleft Lip / Cleft Palate

Cardiac Conditions:

Y	N		Y	N	
☐	☐	Congenital Heart Defects / Artificial Valves	☐	☐	Heart Attack / Stroke
☐	☐	Heart Murmur	☐	☐	Mitral Valve Prolapse
☐	☐	Heart Surgery / Pacemaker	☐	☐	Rheumatic / Scarlet Fever

Respiratory Conditions:

Y	N		Y	N	
☐	☐	Asthma	☐	☐	Sinus Problems
☐	☐	Emphysema	☐	☐	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 Specifiy.

_____

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

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

Reasons for orthodontic consultation (chief concern):

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.**

Patient Name: _____ **Parent/ Guardian Name:** _____

Parent/Guardian Signature: _____ **Date:** _____

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: _____ Parent / Guardian Name: _____

Parent / Guardian 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): _____

Please continue to the next page.....

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!