nova ORTHODONTICS

Dr. Joanna Stoyanova, DDS, MDS, PC

Tell Us About Your Child

Today's Date: _____ /_____ /_____

Child's Full Name: _____ Prefers to be called: _____

Physical Address: _____ City: _____ State: _____ ZIP: _____

Mailing Address *(if different)*: _____ City: _____ State: _____ ZIP: _____

Birth Date: _____ /_____ /_____ Age: _____ ☐ Male ☐ Female How long at current address? _____ Family e-mail: _____

Child's General Dentist: _____ Approximate last visit date: _____ Home #: _____

School: _____ Grade: _____ Hobbies / Sports: _____

Who Is Accompanying Your Child Today?

Name: _____ Relation: _____ Do you have legal custody of this child? ☐ Yes ☐ No

Who may we thank for referring you? _____

List family members we have seen: _____

List additional brothers / sisters with ages: _____

_____

Mother's Information

Name _____ Birth date: _____ /_____ /_____

Address (if different): _____ How long at current address? _____

Cell #: _____ SS#: _____ DL#: _____

Employer: _____ Job Title: _____ How long at current job? _____ Work #: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered ☐ Separated

Spouse's name (if not natural father): _____

Father's Information

Name _____ Birth date: _____ /_____ /_____

Address (if different): _____ How long at current address? _____

Cell #: _____ SS#: _____ DL#: _____

Employer: _____ Job Title: _____ How long at current job? _____ Work #: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered ☐ Separated

Spouse's name (if not natural mother): _____

Third Party Information: ☐ Stepfather ☐ Stepmother ☐ Grandparent ☐ Other _____

Name _____ Birth date: _____ /_____ /_____

Address (if different): _____ How long at current address? _____

Cell #: _____ Home #: _____ Work #: _____

Employer: _____ Job Title: _____ How long at current job? _____

If insurance is involved or if financially responsible, please include the following:

SS#: _____ DL#: _____

Dental Insurance Information

Primary Insurance Company Name: _____

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birth date: _____ /_____ /_____ ID #: _____ Employer: _____

Secondary Insurance Company Name: _____

Policy Owner's Name: _____ Relationship to Patient: _____

Policy Owner's Birth date: _____ /_____ /_____ ID #: _____ Employer: _____

Health History

What are your main concerns regarding the patient's smile? _____

Has your child ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No If so, when? _____

Have there been any injuries to the face, mouth, teeth or chin? ☐ Yes ☐ No If so, please describe: _____

Please list any musical instruments that the patient plays: _____

Have adenoids or tonsils been removed? ☐ Yes ☐ No

Has your child been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Has your child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Does your child brush his / her teeth daily? ☐ Yes ☐ No

Is your child currently under the care of a physician? ☐ Yes ☐ No

Child's Physician: _____ Phone #: _____ Last visit: _____

Please list any drugs that your child is currently taking: _____

Describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor

Has puberty begun? ☐ Yes ☐ No Has menstruation begun (girls)? ☐ Yes ☐ No

Please list all drugs / things that your child is allergic to: _____

Latex: ☐ Yes ☐ No Metals: ☐ Yes ☐ No Plastics: ☐ Yes ☐ No

Has your child ever had any of the following medical problems?

☐ Yes	☐ No	Abnormal Bleeding	☐ Yes	☐ No	Handicaps / Disabilities	☐ Yes	☐ No	Hearing Impairment
☐ Yes	☐ No	ADD / ADHD	☐ Yes	☐ No	Any Hospital Stays	☐ Yes	☐ No	Heart Murmur
☐ Yes	☐ No	Any Operations	☐ Yes	☐ No	Artificial Bones / Joints / Valves	☐ Yes	☐ No	Hepatitis
☐ Yes	☐ No	Asthma	☐ Yes	☐ No	HIV+ / AIDS	☐ Yes	☐ No	Cancer
☐ Yes	☐ No	Kidney / Liver Problems	☐ Yes	☐ No	Congenital Heart Defect	☐ Yes	☐ No	Lupus
☐ Yes	☐ No	Diabetes	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No	Convulsions / Epilepsy
☐ Yes	☐ No	Rheumatic / Scarlet Fever	☐ Yes	☐ No	Hemophilia			

Please discuss any medical problems your child has had: _____

_____

Has your child ever experienced any of the following?

☐ Yes	☐ No	Clenching / Grinding Teeth	☐ Yes	☐ No	Nail Biting	☐ Yes	☐ No	Thumb / Finger Sucking
☐ Yes	☐ No	Lip Sucking / Biting	☐ Yes	☐ No	Nursing Bottle Habits	☐ Yes	☐ No	Tongue Thrust
☐ Yes	☐ No	Mouth Breather	☐ Yes	☐ No	Speech Problems			

I understand that the information that I have provided is correct to the best of my knowledge, and that HIPAA guidelines will be followed regarding this information. I also understand that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services that my child may need.

_____

Signature of Parent or Guardian Date

If this office accepts assignment of benefits for my insurance, I authorize payment directly to Joanna K. Stoyanova, DDS, MDS, PC. If this office does not accept assignment of benefits of my insurance, I understand that the insurance payments will come directly to the insured member, and I will be responsible for reimbursing the office. I am ultimately responsible for any fees or deductibles that are not covered by my insurance plan.

_____

Signature of Parent or Guardian Date

The parent or guardian who accompanies the child is responsible for payment

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein. Initials ____ Date_____

Doctor's Comments: _____

_____

_____

_____

_____

_____