nova ORTHODONTICS

Dr. Joanna Stoyanova, DDS, MDS, PC

Tell Us About You

Today's Date: _____ /_____ /_____

Full Name:_____ I prefer 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? _____

SS#_____ DL#_____ e-mail _____

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

Employer:_____ Occupation: _____

How long at current job?_____ When / where are best times to reach you? _____

Who may we thank for referring you?_____

Have we seen any of your family members? _____

General Dentist:_____ Last Visit Date: _____

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

Spouse Information

Name: _____ Birth Date:_____ /_____ /_____

Employer: _____ Occupation: _____

Work #: _____ How long at current job?_____

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

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:_____

In case of emergency, please list a contact person other than your spouse.

Name: _____ Relation: _____

Work #:_____ Home #:_____

Dental History

What are your main concerns that you would like orthodontics to accomplish?_____

_____

Have you ever been evaluated or had orthodontic treatment before? ☐ Yes ☐ No If so, when? _____

Have you ever had a serious / difficult situation associated with any previous dental work? ☐ Yes ☐ No

Please explain:_____

How would you describe your current dental health? ☐ Good ☐ Fair ☐ Poor

Do you like your smile? ☐ Yes ☐ No Do your gums ever bleed? ☐ Yes ☐ No

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

_____

Have you ever experienced pain / discomfort in your jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Have you ever been informed of any missing or extra permanent teeth? ☐ Yes ☐ No

Do you have any speech problems? _____

Do you generally breathe through your mouth? ☐ Yes ☐ No If so, while asleep or awake? *(please circle one)*

Do you use tobacco of any kind? ☐ Yes ☐ No

Health History

Are you currently under the care of a physician? ☐ Yes ☐ No

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

Please explain: _____

Ladies, are you pregnant? ☐ Yes ☐ No How many weeks? _____ Are you nursing? ☐ Yes ☐ No

Please list any medications that you are currently taking? _____

Describe your current physical health: ☐ Good ☐ Fair ☐ Poor

Have you ever had any of the following medical diseases or medical problems?

☐ Yes	☐ No	Abnormal Bleeding	☐ Yes	☐ No	Anemia	☐ Yes	☐ No	Artificial Bones / Joints / Valves
☐ Yes	☐ No	Asthma	☐ Yes	☐ No	Arthritis	☐ Yes	☐ No	Blood Transfusion
☐ Yes	☐ No	Cancer / Chemotherapy	☐ Yes	☐ No	Congenital Heart Defect	☐ Yes	☐ No	Diabetes
☐ Yes	☐ No	Difficulty Breathing	☐ Yes	☐ No	Drug / Alcohol Abuse	☐ Yes	☐ No	Emphysema
☐ Yes	☐ No	Epilepsy / Seizures / Fainting	☐ Yes	☐ No	Fever Blisters / Herpes	☐ Yes	☐ No	Glaucoma
☐ Yes	☐ No	Heart Attack / Stroke	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No	Heart Surgery / Pacemaker
☐ Yes	☐ No	Hemophilia	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No	High / Low Blood Pressure
☐ Yes	☐ No	HIV+ / AIDS	☐ Yes	☐ No	Hospitalization	☐ Yes	☐ No	Kidney Problems
☐ Yes	☐ No	Mitral Valve Prolapse	☐ Yes	☐ No	Psychiatric Problems	☐ Yes	☐ No	Radiation Treatment
☐ Yes	☐ No	Rheumatic / Scarlet Fever	☐ Yes	☐ No	Severe Headaches	☐ Yes	☐ No	Shingles
☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No	Sinus Problems	☐ Yes	☐ No	Tuberculosis
☐ Yes	☐ No	Ulcers / Colitis	☐ Yes	☐ No	Venereal Disease			

Please list any serious medical condition(s) that you have ever had: _____

_____

Are you allergic to any of the following?

☐ Yes	☐ No	Aspirin	☐ Yes	☐ No	Dental Anesthetics	☐ Yes	☐ No	Penicillin
☐ Yes	☐ No	Any Metals / Plastics	☐ Yes	☐ No	Erythromycin	☐ Yes	☐ No	Tetracycline
☐ Yes	☐ No	Codeine	☐ Yes	☐ No	Latex	☐ Yes	☐ No	Other

Please list any other drugs / materials that you are allergic to: _____

_____

_____

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 medical status. I authorize the dental staff to perform the necessary dental services that I may need.

_____

Signature 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 Date

This office reserves the right to verify the credit status of financially responsible parties prior to extending credit for treatment fees, and may use the services of a credit reporting institution.

_____

Signature Date

OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the patient named herein. Initials _____ Date _____

Doctor's Comments: _____

_____