Welcome to the Orthodontic office of Dr. Tara Gostovich!

Please take a few minutes to fill out this necessary information that will enable us to better serve you. Our staff will be happy to assist you with any questions you may have.

PATIENT INFORMATION: Today's date: _____

Patient's Name: _____
Last First Middle

Nickname: _____ _____ SSN: _____

Birth date: _____ Age: _____ Male: _____ Female: _____

Home Address: _____

Home Phone #: (_____) _____ Patient lives with: _____

E-Mail Address: _____

May we have your consent to communicate via text: Y/N

FAMILY INFORMATION:

Mother's Name: _____ Occupation: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Address (if different from above): _____

Father's Name: _____ Occupation: _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Address (if different from above): _____

Other Children in Family (Name & Age): _____

PERSON RESPONSIBLE FOR ACCOUNT:

Name: _____ Relation to patient: _____

Billing Address: _____

Previous Address: _____

Employer: _____ Phone #: _____

SSN: _____ Driver's License #: _____

Who is responsible for making appointments? _____

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

Emergency Contact: _____
Name Relation to patient

Home Phone: _____ Work Phone: _____ Mobile Phone: _____

INSURANCE:

Primary Orthodontic Insurance:

Insurance Company's Name: _____ Ins. Co. Phone #: _____

Insurance Company's Address: _____

ID#: _____ Group #: _____ Ortho Coverage Y/N: _____

Policy Owner's Name: _____ Relation to patient: _____

Policy Owner's DOB: _____ Policy Owner's Employer: _____

Employer's Address: _____

Secondary Orthodontic Insurance:

Insurance Company's Name: _____ Ins. Co. Phone #: _____

Insurance Company's Address: _____

ID#: _____ Group #: _____ Ortho Coverage Y/N: _____

Policy Owner's Name: _____ Relation to patient: _____

Policy Owner's DOB: _____ Policy Owner's Employer: _____

Employer's Address: _____

MEDICAL HISTORY:

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

Address: _____

Current medical health: Excellent _____ Good _____ Fair _____ Poor _____

Is patient currently under the care of a physician? If yes, please explain: _____

_____

Is patient taking any medications? Y/N If so, list: _____

Does patient have any allergies: Y/N What? (aspirin, metals, plastics, antibiotics, latex) _____

Has patient ever had any of the following diseases or medical problems?

Y/N	Abnormal bleeding	Y/N	Diabetes	Y/N	High/Low Blood Pressure
Y/N	Anemia	Y/N	Difficulty Breathing	Y/N	HIV+/AIDS
Y/N	Artificial joints/valves	Y/N	Drug/Alcohol Abuse	Y/N	Hospitalization/Surgery
Y/N	Arthritis	Y/N	Epilepsy/Seizures	Y/N	Kidney Problems
Y/N	Asthma	Y/N	Fever Blisters/Herpes	Y/N	Psych/Emotional Problems
Y/N	Birth Defects	Y/N	Glaucoma	Y/N	Rheumatic/Scarlet Fever
Y/N	Blood transfusions	Y/N	Heart Disease	Y/N	Severe/Frequent Headaches
Y/N	Cancer/Chemotherapy	Y/N	Heart Murmur	Y/N	Sinus Problems
Y/N	Congenital Heart Defect	Y/N	Hepatitis	Y/N	Tuberculosis
Y/N	ADD/ADHD				

Other: _____

Please list any serious past or current medical problems: _____

Female patients: Has patient reached menstruation/puberty? Y/N Are you pregnant? Y/N Week #: _____

DENTAL HISTORY:

Dentist's Name: _____ Last Visit: _____ Phone #: _____

Address: _____

Current dental health: Excellent _____ Good _____ Fair _____ Poor _____

Has patient ever had a serious/difficult problem associated with any previous dental work? Y/N

Has patient ever been evaluated for orthodontic treatment? Y/N

Habits:

Y/N	Clenching/Grinding Teeth	Y/N	Thumb/Finger sucking	Y/N	Tongue thrust
Y/N	Mouth Breather	Y/N	Nail Biting	Y/N	Speech Problems

Has patient ever experienced:

Y/N Pain/discomfort in the jaw joint? Explain: _____

Y/N Locked jaw? Open lock _____ Closed lock _____ Associated with pain? Y/N

Y/N Clicking or popping? Right ____ Left ____ upon opening ____ upon closing ____ Assoc. w/ pain? Y/N

Y/N Frequent/Severe Headaches? upon waking ____ during the day ____ Location of pain _____

Has patient ever had an injury to the: face _____ mouth _____ teeth _____ chin _____

Why are you currently seeking treatment? What would you like orthodontic treatment to accomplish? _____

_____

Would you like to see an improvement in the patient's facial appearance? Y/N How? _____

Has patient ever taken Fosamax, Actonel, Bonivia or any other bisphosphonate? _____

Does patient smoke or use tobacco in any form? _____

To the best of my knowledge, all the preceding answers are correct. I understand that this information will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes in my/my child's medical status. I hereby give permission to Dr. Tara Gostovich and her clinical team to take any x-rays, photographs and/or study models deemed necessary to enable complete diagnosis and treatment planning.

_____ _____ _____

Patient / Parent or Guardian Signature Relation Date

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting agencies.

If this office accepts insurance, I understand that I am responsible for payment of services rendered for which my insurance does not cover.

_____ _____

Signature Date Signature Date

Our office is HIPPA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

~ FOR OFFICE USE ONLY ~

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

Doctor's Comments: _____

_____

_____

_____