Petrover ORTHODONTICS.com
Love Your Smile

Welcome to Petrover Orthodontics!

ABOUT YOU

NAME: _____ PREFERRED NAME: _____

DATE OF BIRTH: _____ AGE: _____

WHO MAY WE THANK FOR REFERRING YOU? _____

OTHER FAMILY MEMBERS SEEN BY US: _____

WHY HAVE YOU COME TO THE ORTHODONTIST? _____

HOME ADDRESS: _____ CITY: _____ ZIP: _____

HOME PHONE #: (_____)_____ CELL PHONE #: (_____)_____

WORK PHONE #: (_____)_____ BEST CONTACT PHONE #: ❑HOME/ ❑CELL / ❑WORK/ ❑EMAIL

EMAIL: _____

SS#: _____ DL#: _____

RESPONSIBLE PARTY INFORMATION:

❑ SELF — PLEASE SKIP THIS SECTION.

NAME: _____

RELATIONSHIP: _____

ADDRESS: ❑ SAME AS PATIENT_____ CITY: _____ ZIP: _____

HOME PHONE #: ❑ SAME AS PATIENT (_____) _____CELL PHONE #: (_____) _WORK PHONE #: (_____) _____

EMAIL: _____

EMERGENCY CONTACT:

NAME: _____

RELATIONSHIP: _____

HOME PHONE #: (____) _____

CELL PHONE #: (____) _____

WORK PHONE #: (____) _____

EMAIL: _____

PRIMARY DENTAL INSURANCE:

INSURED'S NAME: _____

RELATIONSHIP TO PATIENT: _____

INSURED'S DOB: _____

INSURED'S SS #: _____

INSURED'S ID #: _____

GROUP #: _____

INSURANCE COMPANY NAME: _____

INSURANCE COMPANY ADDRESS: _____

_____

INSURANCE COMPANY PHONE #: (_____) _____

NAME OF EMPLOYER: _____

SECONDARY DENTAL INSURANCE:

INSURED'S NAME: _____

RELATIONSHIP TO PATIENT: _____

INSURED'S DOB: _____

INSURED'S SS #: _____

INSURED'S ID #: _____

GROUP #: _____

INSURANCE COMPANY NAME: _____

INSURANCE COMPANY ADDRESS: _____

_____

INSURANCE COMPANY PHONE #: (_____) _____

NAME OF EMPLOYER: _____

PATIENT DENTAL / MEDICAL HISTORY

NAME OF GENERAL DENTIST: _____

PHONE #: (_____)_____

LAST TIME YOU WERE SEEN BY A GENERAL DENTIST?

DO YOU LIKE YOUR SMILE? _____ ❑YES ❑NO

ARE YOU CURRENTLY IN PAIN? _____ ❑YES ❑NO

DO YOU HAVE ANY PENDING DENTAL WORK? _____ ❑YES ❑NO

HAVE YOU EVER HAD ANY SERIOUS/DIFFICULT PROBLEM ASSOCIATED WITH PREVIOUS DENTAL WORK? _____ ❑YES ❑NO

HAVE YOU EVER HAD ANY PAIN OR TENDERNESS IN THE JAW JOINT (TMJ)? _____ ❑YES ❑NO

DO YOUR GUMS EVER BLEED? _____ ❑YES ❑NO

HOW MANY TIMES A WEEK DO YOU FLOSS? _____

HOW MANY TIMES A WEEK DO YOU BRUSH? _____

TYPE OF TOOTH BRUSH BRISTLES: _____ ❑HARD ❑MEDIUM ❑SOFT

DO YOU HAVE A PERSONAL PHYSICIAN? _____ ❑YES ❑NO

NAME: _____ PHONE #: _____

YOUR CURRENT PHYSICAL HEALTH IS: _____ ❑GOOD ❑FAIR ❑POOR

ARE YOU CURRENTLY UNDER THE CARE OF A DOCTOR? _____ ❑YES ❑NO

EXPLAIN: _____

ARE YOU TAKING ANY PRESCRIPTION DRUGS? ❑YES ❑NO

LIST: _____

YES	NO	
❑	❑	HEART MURMUR
❑	❑	CANCER
❑	❑	DIABETES
❑	❑	RHEUMATIC FEVER
❑	❑	HIV+/AIDS
❑	❑	HEMOPHILIA
❑	❑	ASTHMA
❑	❑	HEPATITIS
❑	❑	TUBERCULOSIS
❑	❑	HEART ATTACK
❑	❑	KIDNEY/LIVER PROBLEMS
❑	❑	SHINGLES
❑	❑	FEVER BLISTER
❑	❑	ULCERS/COLITIS
❑	❑	EMPHYSEMA
❑	❑	SINUS PROBLEMS
❑	❑	PROSTHESIS
❑	❑	DIFFICULTY BREATHING

YES	NO	
❑	❑	CONGENITAL HEART DEFECT
❑	❑	CONVULSIONS/EPILEPSY
❑	❑	ABNORMAL BLEEDING
❑	❑	HEARING IMPAIRMENT
❑	❑	ANY OPERATIONS
❑	❑	ANY STAYS IN HOSPITAL
❑	❑	HANDICAPS/DISABILITIES
❑	❑	ALLERGIES TO ANY DRUGS
❑	❑	HISTORY OF SCARLET FEVER
❑	❑	ARTIFICIAL VALVES
❑	❑	HEART SURGERY/PACEMAKER
❑	❑	MITRAL VALVE PROLAPSE
❑	❑	ARTIFICIAL BONES/JOINTS
❑	❑	SEVERE/FREQUENT HEADACHES
❑	❑	HI/LOW BLOOD PRESSURE
❑	❑	DRUG/ALCOHOL ABUSE
❑	❑	BLOOD TRANSFUSION
❑	❑	ANEMIA/RADIATION TREATMENT
❑	❑	GLAUCOMA

OTHER: _____

FOR WOMEN ONLY

ARE YOU TAKING BIRTH CONTROL PILLS? ❑YES ❑NO

ARE YOU PREGNANT? ❑YES ❑NO WEEK #: _____

ARE YOU NURSING? ❑YES ❑NO

ARE YOU ALLERGIC TO ANY OF THE FOLLOWING?

LATEX	❑YES ❑NO
METAL	❑YES ❑NO
ASPIRIN	❑YES ❑NO
CODEINE	❑YES ❑NO
PENICILIN	❑YES ❑NO
ERYTHROMYCIN	❑YES ❑NO
TETRACYCLINE	❑YES ❑NO

I UNDERSTAND THE INFORMATION THAT I HAVE GIVEN IS CORRECT TO THE BEST OF MY KNOWLEDGE, THAT IT WILL BE HELD IN THE STRICTEST CONFIDENCE, AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES IN MY MEDICAL STATUS.

SIGNATURE: _____ DATE: _____

RELEASE FORM

Grant of Rights.
For valuable consideration received, I _____ hereby grant to_____("Grantee") the absolute and irrevocable right and permission, throughout the world, in respect of the photographs and video it has taken of me or acquired of me:

1. To use, re-use, publish and re-publish and otherwise reproduce, distribute, publicly display and publicly perform the same, in whole or in part, in any and all media including practice website and social media, now or hereafter known for illustration, promotion, advertising, trade or any other purpose whatsoever; and

2. To use my name and written testimonial in connection with the Material if it so chooses.

Release
I hereby release and discharge Grantee from any claims and demands arising out of or in connection with the use of the materials, including without limitation any and all claims for defamation, invasion of privacy, and misappropriation of my right of publicity.

Grantor's Representations
I have read the foregoing and fully understand the contents thereof. This release shall be binding upon me and my heirs, legal representatives and assigns.

Name: _____

Signed: _____
(Guardian Signature if under 18)

Date: _____

Address: _____

City, State, Zip: _____

Phone: _____

❑ **Please check this box, if you decline written testimonial and photo usage to Petrover Orthodontics**

Petrover Orthodontics
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Wellington, FL 33414
561-795-3055

9804 S. Military Trail, #E-4
Boynton Beach, FL 33436
561-364-0013

www.petroverorthodontics.com

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Patient First & Last Name: _____

Address: _____

Telephone: _____

Patient SSN #: _____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to it carefully and completely before signing this Consent.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy, including any revisions of our Notice, at any time by contacting:
Dr. Jonathan S. Petrover 2465 State Road 7, Suite 600, Wellington, FL 33414

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry our treatment, payment activities and healthcare operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I revoked my Consent.

Signature: _____ Date: _____