2465 S. State Road 7, Ste 600 Wellington, FL 33414
9804 S. Military Trail, Ste E4 Boynton Beach, FL 33436

Petrover ORTHODONTICS
JONATHAN S. PETROVER, D.D.S.

PATIENT'S NAME: _____

DATE OF BIRTH: _____

| | Y | N |
|---|---|---|
| 1. ARE YOU UNDER MEDICAL TREATMENT NOW? | ☐ | ☐ |
| 2. HAVE YOU BEEN HOSPITALIZED FOR ANY SURGICAL OPERATIONS OR SERIOUS ILLNESS IN THE PAST FIVE YEARS? | ☐ | ☐ |
| 3. ARE YOU TAKING MEDICATION(S) INCLUDING NON-PRESCRIPTION MEDICINE? | ☐ | ☐ |
| 4. DO YOU USE TOBACCO? | ☐ | ☐ |
| 5. ARE YOU AWARE OF BEING ALLERGIC TO ANY MEDICATIONS OR SUBSTANCE, INCLUDING METALS? | ☐ | ☐ |
| 6. EVER TAKEN BISPHOSPHONATES (EX: FOSAMAX) FOR OSTEOPOROSIS? | ☐ | ☐ |

IF YES, WHAT MEDICATION(S) ARE YOU TAKING?

_____

IF YES, WHAT?

_____

IF YES, SPECIFY _____

7. PLEASE CHECK ALL THAT APPLY:

| | | | |
|---|---|---|---|
| HAY FEVER/ALLERGIES | ☐ | LEUKEMIA | ☐ |
| COLD SORES | ☐ | KIDNEY/LIVER DISEASE | ☐ |
| MIGRAINES | ☐ | ANEMIA | ☐ |
| DIABETES/GLAUCOMA | ☐ | CANCER | ☐ |
| RHEUMATIC FEVER | ☐ | JOINT REPLACEMENT/IMPLANT | ☐ |
| AIDS OR HIV INFECTION | ☐ | HEPATITIS/JAUNDICE | ☐ |
| CARDIAC PACEMAKER | ☐ | STOMACH TROUBLES/ULCERS | ☐ |
| ASTHMA (INHALER) | ☐ | SINUS PROBLEMS | ☐ |
| FAINTING/SEIZURES | ☐ | STROKE | ☐ |
| THYROID PROBLEM | ☐ | RADIATION THERAPY | ☐ |
| HIGH/LOW BLOOD PRESSURE | ☐ | RESPIRATORY PROBLEMS | ☐ |
| HEART TROUBLE | ☐ | BONE DISORDER | ☐ |
| EPILEPSY/CONVULSIONS | ☐ | OSTEOPEMIA/OSTEOPOROSIS | ☐ |
| REMOVAL OF ADENOIDS/TONSILS | ☐ | | |

8. *FEMALES ONLY:* ARE YOU PREGNANT, OR THINK YOU MAY BE? ☐ ☐

| | Y | N |
|---|---|---|
| 1. ARE YOU ANXIOUS OR NERVOUS ABOUT DENTAL TREATMENT? | ☐ | ☐ |
| 2. DO YOU REQUIRE PREMEDICATION FOR DENTAL TREATMENT? | ☐ | ☐ |
| 3. DO YOU FEEL PAIN TO ANY OF YOUR TEETH? | ☐ | ☐ |
| 4. DO YOU HAVE ANY SORES OR LUMPS IN OR NEAR YOUR MOUTH? | ☐ | ☐ |
| 5. HAVE YOU HAD ANY HEAD, NECK, OR JAW INJURIES? | ☐ | ☐ |

IF YES, PLEASE DESCRIBE:

_____

| | | |
|---|---|---|
| 6. DO YOU HAVE ANY ONGOING PROBLEMS IN YOUR JAW WITH: | | |
| A. CHRONIC CLICKING OR POPPING? | ☐ | ☐ |
| B. PAIN? | ☐ | ☐ |
| C. DIFFICULTY OPENING OR CLOSING? | ☐ | ☐ |
| D. DIFFICULTY IN CHEWING? | ☐ | ☐ |
| 7. DO YOU CLENCH OR GRIND YOUR TEETH? | ☐ | ☐ |
| 8. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY? | ☐ | ☐ |
| 9. HAVE YOU EVER HAD SPEECH THERAPY? | ☐ | ☐ |

IF YES, PLEASE DESCRIBE:

_____

| | | |
|---|---|---|
| 10. IS THERE ANY OUTSTANDING DENTAL TREATMENT TO BE COMPLETED? | ☐ | ☐ |

IF YES, PLEASE DESCRIBE:

_____

| | | |
|---|---|---|
| 11. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING AND FLOSSING YOUR TEETH? | ☐ | ☐ |
| 12. DO YOU HAVE ANY OF THE FOLLOWING ORAL HABITS: | | |
| A. NAIL BITING? | ☐ | ☐ |
| B. THUMB SUCKING? | ☐ | ☐ |
| C. TONGUE THRUST WHILE SWALLOWING? | ☐ | ☐ |
| D. MOUTH BREATHING? | ☐ | ☐ |

13. HOW MANY TIMES A DAY DO YOU BRUSH? _____

14. PLEASE CHECK THE BOXES BELOW WHICH DESCRIBE THE PROBLEM(S) FOR WHICH YOU ARE SEEKING ORTHODONTIC TREATMENT:

| | | | |
|---|---|---|---|
| CROWDING | ☐ | MISSING TEETH | ☐ |
| EXTRA SPACE | ☐ | EXTRA PERMANENT TEETH | ☐ |
| TEETH STICK OUT TOO FAR | ☐ | TEETH ERUPTING IN THE WRONG POSITION | ☐ |
| TMJ PROBLEMS | ☐ | | |
| POOR BITE RELATIONSHIP | ☐ | OTHER: _____ | |

15. HAS THE PATIENT HAD AN ORTHODONTIC EVALUATION OR TREATMENT BEFORE? ☐ ☐

IF SO, WHEN AND BY WHOM?

## Authorization and Release

TO THE BEST OF MY KNOWLEDGE THE ABOVE QUESTIONS HAVE BEEN ACCURATELY ANSWERED AND IT IS MY RESPONSIBILITY TO INFORM THIS OFFICE OF ANY CHANGES TO THE PATIENT'S MEDICAL STATUS. I GIVE PETROVER ORTHODONTICS PERMISSION TO PERFORM THE NECESSARY DENTAL SERVICES THAT THE PATIENT MAY NEED.

I HEREBY GRANT TO PETROVER ORTHODONTICS THE ABSOLUTE AND IRREVOCABLE RIGHT AND PERMISSION, THROUGHOUT THE WORLD, IN RESPECT OF THE PHOTOGRAPHS AUDIO, 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. 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.

PATIENT OR LEGAL GUARDIAN SIGNATURE:

DATE _____