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: ______________________________

HOME PHONE #: (_______)______________________ CELL PHONE #: (_______)______________________

WORK PHONE #: (_______)______________________ BEST CONTACT PHONE #: HOME / CELL / WORK

EMAIL: ______________________________

SS#: ______________________________

DL#: ______________________________

RESPONSIBLE PARTY INFORMATION:

❑ SELF — PLEASE SKIP THIS SECTION.

NAME: ______________________________

RELATIONSHIP: ______________________________

ADDRESS: ❑ SAME AS PATIENT______________________________

HOME PHONE #: ❑ SAME AS PATIENT (_______) ______________________________

CELL PHONE #: (_______) ______________________________

WORK PHONE #: (______) ______________________________

EMAIL: ______________________________

EMERGENCY CONTACT:

❑ SAME AS RESPONSIBLE PARTY — PLEASE SKIP THIS SECTION.

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 #: (_____)______________________

DO YOU LIKE YOUR SMILE? ______________________ ❑YES ❑NO

ARE YOU CURRENTLY IN PAIN? ______________________ ❑YES ❑NO

YOUR CURRENT DENTAL HEALTH IS: ______________________ ❑GOOD ❑FAIR ❑POOR

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
❑	❑	VENEREAL DISEASE
❑	❑	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?

ASPIRIN	❑YES ❑NO
CODEINE	❑YES ❑NO
LATEX	❑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: ______________________

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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: ______________