



Welcome to Petrover Orthodontics!

ABOUT YOUR CHILD

CHILD'S NAME: _____
 PREFERRED NAME: _____
 DATE OF BIRTH: _____ AGE: _____
 WHO MAY WE THANK FOR REFERRING YOU? _____
 OTHER FAMILY MEMBERS SEEN BY US: _____
 WHY HAVE YOU BROUGHT YOUR CHILD TO THE ORTHODONTIST? _____
 WHO IS WITH THE CHILD TODAY? _____
 NAME: _____
 RELATIONSHIP: _____

MOTHER'S INFORMATION:

NAME: _____
 ADDRESS: _____
 HOME PHONE #: (_____) _____
 CELL PHONE #: (_____) _____
 WORK PHONE#: (_____) _____
 EMAIL: _____
 SS #: _____
 DL#: _____

FATHER'S INFORMATION:

NAME: _____
 ADDRESS: SAME AS MOTHER'S _____
 HOME #: SAME AS MOTHER'S _____
 CELL PHONE #: (_____) _____
 WORK PHONE #: (_____) _____
 EMAIL: _____
 SS #: _____
 DL #: _____

RESPONSIBLE PARTY:

MOTHER — IF YES, PLEASE SKIP THIS SECTION. FATHER — IF YES, PLEASE SKIP THIS SECTION. OTHER — IF YES, PLEASE FILL OUT THIS SECTION.

NAME: _____
 RELATIONSHIP: _____
 ADDRESS: _____
 HOME PHONE #: (_____) _____
 CELL PHONE #: (_____) _____
 WORK PHONE #: (_____) _____
 EMAIL: _____
 SS #: _____
 DL #: _____

BEST CONTACT:

NAME: _____
 BEST CONTACT PHONE #: _____

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 #: (_____) _____

HAS THE CHILD EVER HAD A SERIOUS/DIFFICULT PROBLEM ASSOCIATED WITH DENTAL WORK? _____ YES NO

HAVE THE TONSILS/ADENOIDS BEEN REMOVED? _____ YES NO

IS THE CHILD'S WATER FLUORIDATED? _____ YES NO

IS THE CHILD TAKING FLUORIDATED SUPPLEMENTS? _____ YES NO

HAS THE CHILD EVER HAD ANY PAIN OR TENDERNESS IN THE JAW JOINT (TMJ)? _____ YES NO

DOES THE CHILD BRUSH TEETH DAILY? _____ YES NO

FLOSS THEIR TEETH DAILY? _____ YES NO

IS THE CHILD CURRENTLY UNDER THE CARE OF A PHYSICIAN? _____ YES NO

EXPLAIN: _____

CHILD'S PHYSICIAN? _____

PHONE #: (_____) _____

PLEASE DESCRIBE THE CHILD'S HEALTH: _____ GOOD FAIR POOR

PLEASE LIST ALL DRUGS THE CHILD IS CURRENTLY TAKING: _____

PLEASE LIST ALL DRUGS THE CHILD IS ALLERGIC TO: _____

YES NO

- HEART MURMUR
- CANCER
- DIABETES
- RHEUMATIC FEVER
- HIV+/AIDS
- HEMOPHILIA
- ASTHMA
- HEPATITIS
- TUBERCULOSIS
- PROSTHESIS
- ALLERGIC TO LATEX & METAL
- CONGENITAL HEART DEFECT
- CONVULSIONS/EPILEPSY
- ABNORMAL BLEEDING
- HEARING IMPAIRMENT

YES NO

- ANY OPERATIONS
- ANY STAYS IN HOSPITAL
- ADD OR ADHD
- CONGENITAL HEART DEFECT
- CONVULSIONS/EPILEPSY
- ABNORMAL BLEEDING
- HEARING IMPAIRMENT
- HEART SURGERY/PACEMAKER
- ANY OPERATIONS
- ANY STAYS IN HOSPITAL
- KIDNEY/LIVER PROBLEMS
- HANDICAPS/DISABILITIES
- ALLERGIES TO ANY DRUGS
- HISTORY OF SCARLET FEVER

OTHER: _____

PLEASE DISCUSS ANY SERIOUS MEDICAL PROBLEMS THAT THE CHILD HAS HAD: _____

DOES THE CHILD HAVE ANY OF THE FOLLOWING HABITS?

YES NO

- THUMB SUCKING / FINGER SUCKING
- LIP SUCKING / BITING

YES NO

- NAIL BITING
- NURSING BOTTLE HABITS

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 CHILD'S MEDICAL STATUS.

SIGNATURE OF PARENT/GUARDIAN: _____ DATE: _____

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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 read 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 out 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: _____

REVOCAION 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: _____