

FULL NAME: _____

DATE OF BIRTH: _____

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

7. PLEASE CHECK ALL THAT APPLY:
- | | | | |
|-----------------------------|--------------------------|---------------------------|--------------------------|
| HAY FEVER/ALLERGIES | <input type="checkbox"/> | LEUKEMIA | <input type="checkbox"/> |
| COLD SORES | <input type="checkbox"/> | KIDNEY/LIVER DISEASE | <input type="checkbox"/> |
| MIGRAINES | <input type="checkbox"/> | ANEMIA | <input type="checkbox"/> |
| DIABETES/GLAUCOMA | <input type="checkbox"/> | CANCER | <input type="checkbox"/> |
| RHEUMATIC FEVER | <input type="checkbox"/> | JOINT REPLACEMENT/IMPLANT | <input type="checkbox"/> |
| AIDS OR HIV INFECTION | <input type="checkbox"/> | HEPATITIS/JAUNDICE | <input type="checkbox"/> |
| CARDIAC PACEMAKER | <input type="checkbox"/> | STOMACH TROUBLES/ULCERS | <input type="checkbox"/> |
| ASTHMA (INHALER) | <input type="checkbox"/> | SINUS PROBLEMS | <input type="checkbox"/> |
| FAINTING/SEIZURES | <input type="checkbox"/> | STROKE | <input type="checkbox"/> |
| THYROID PROBLEM | <input type="checkbox"/> | RADIATION THERAPY | <input type="checkbox"/> |
| HIGH/LOW BLOOD PRESSURE | <input type="checkbox"/> | RESPIRATORY PROBLEMS | <input type="checkbox"/> |
| HEART TROUBLE | <input type="checkbox"/> | BONE DISORDER | <input type="checkbox"/> |
| EPILEPSY/CONVULSIONS | <input type="checkbox"/> | OSTEOPEMIA/OSTEOPOROSIS | <input type="checkbox"/> |
| REMOVAL OF ADENOIDS/TONSILS | <input type="checkbox"/> | | |

8. FEMALES ONLY: ARE YOU PREGNANT, OR THINK YOU MAY BE? Y N

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:

- 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
- 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.

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

IF YES, PLEASE DESCRIBE: _____

6. DO YOU HAVE ANY ONGOING PROBLEMS IN YOUR JAW WITH:
- | | | |
|--|--------------------------|--------------------------|
| A. CHRONIC CLICKING OR POPPING? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. PAIN? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. DIFFICULTY OPENING OR CLOSING? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. DIFFICULTY IN CHEWING? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. DO YOU CLENCH OR GRIND YOUR TEETH? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. DO YOU BITE YOUR LIPS OR CHEEKS FREQUENTLY? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. HAVE YOU EVER HAD SPEECH THERAPY? | <input type="checkbox"/> | <input type="checkbox"/> |
- IF YES, PLEASE DESCRIBE: _____

10. IS THERE ANY OUTSTANDING DENTAL TREATMENT TO BE COMPLETED? Y N
 IF YES, PLEASE DESCRIBE: _____

11. HAVE YOU EVER HAD INSTRUCTION ON THE CORRECT METHOD OF BRUSHING AND FLOSSING YOUR TEETH? Y N

12. DO YOU HAVE ANY OF THE FOLLOWING ORAL HABITS:
- | | | |
|------------------------------------|--------------------------|--------------------------|
| A. NAIL BITING? | <input type="checkbox"/> | <input type="checkbox"/> |
| B. THUMB SUCKING? | <input type="checkbox"/> | <input type="checkbox"/> |
| C. TONGUE THRUST WHILE SWALLOWING? | <input type="checkbox"/> | <input type="checkbox"/> |
| D. MOUTH BREATHING? | <input type="checkbox"/> | <input type="checkbox"/> |

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 | <input type="checkbox"/> | MISSING TEETH | <input type="checkbox"/> |
| EXTRA SPACE | <input type="checkbox"/> | EXTRA PERMANENT TEETH | <input type="checkbox"/> |
| TEETH STICK OUT TOO FAR | <input type="checkbox"/> | TEETH ERUPTING IN THE WRONG POSITION | <input type="checkbox"/> |
| TMJ PROBLEMS | <input type="checkbox"/> | OTHER: _____ | |
| POOR BITE RELATIONSHIP | <input type="checkbox"/> | | |

15. HAS THE PATIENT HAD AN ORTHODONTIC EVALUATION OR TREATMENT BEFORE? Y N
 IF SO, WHEN AND BY WHOM? _____

PATIENT SIGNATURE

DATE _____