

Christopher Parkinson, DDS, MS Orthodontic Specialist

*We would like to welcome you to our office. Our goal is to make every visit pleasant and educational.
We strive to teach good oral care that will enable you to have a beautiful smile that lasts a lifetime.*

Patient Information:

Your Name: _____
Birth Date: _____/_____/_____ Age: _____ Sex: Male Female Common Name: _____ MI
Address: _____
Home Telephone #: _____ Work Telephone #: _____ ext _____ City _____ State _____ Zip Code _____
Employer: _____ Social Security #: _____/_____/_____ Driver License #: _____ State: _____
E-mail address to receive account and appointment information: _____
In the event of an emergency who can we contact? _____ Relation: _____
Home Telephone #: _____ Last Name _____ First Name _____
Work Telephone #: _____ ext _____ Cell Phone #: _____
List Family Members Currently In Our Practice: _____

Spouse Information:

Marital Status: Single Widowed Married Divorced Separated
Spouse's Name: _____ Birth Date: _____/_____/_____ MI
Address: _____
Home Telephone #: _____ Work Telephone #: _____ ext _____ City _____ State _____ Zip Code _____
Employer: _____ Social Security #: _____/_____/_____ Driver License #: _____ State: _____

Financial Information:

Who Is Financially Responsible For This Account? _____
Relationship To Patient: _____ Last Name _____ First Name _____ MI
Billing Address: _____
Home Telephone #: _____ Work Telephone #: _____ ext _____ City _____ State _____ Zip Code _____
Employer: _____ Social Security #: _____/_____/_____ Driver License #: _____ State: _____

This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

Signature of Patient

Date

Insurance Information:

Primary Insurance Holder's Name: _____
Last First MI

Insurance Coverage For Dental Treatment: YES NO Insurance Coverage For Orthodontic Treatment? YES NO

Relationship to Patient: _____ Policy Holder's Social Security #: ____/____/____ Policy Holder's Birth Date: ____/____/____

Policy Holder's Employer: _____

Insurance Company: _____ Policy #: _____

Insurance Company Address: _____
City State Zip Code Telephone #

I authorize Dr. Parkinson to release any information to process insurance claims upon starting orthodontic treatment. I also authorize my insurance benefits to be paid directly to Dr. Parkinson.

Signature of Primary Insurance Subscriber Date

Secondary Insurance Holder's Name: _____
Last First MI

Insurance Coverage For Dental Treatment: YES NO Insurance Coverage For Orthodontic Treatment? YES NO

Relationship to Patient: _____ Policy Holder's Social Security #: ____/____/____ Policy Holder's Birth Date: ____/____/____

Policy Holder's Employer: _____

Insurance Company: _____ Policy #: _____

Insurance Company Address: _____
City State Zip Code Telephone #

I authorize Dr. Parkinson to release any information to process insurance claims upon starting orthodontic treatment. I also authorize my insurance benefits to be paid directly to Dr. Parkinson.

Signature of Secondary Insurance Subscriber Date

Dentist Information:

Name of Patient's Dentist: _____ Telephone #: _____
Name City State

Date Last Seen: _____ Reason: _____

Who suggested that you might need orthodontic treatment? _____

What is your primary concern? Why are you here? _____

Whom may we thank for referring you? _____

Why did you select our office? _____

For the following questions, please mark yes, no or don't know/understand (dk/u). The answers are for office records only and will be considered confidential. A thorough and complete history is vital to a proper orthodontic evaluation.

PATIENT PROFILE

- yes no dk/u Does the patient follow directions well?
yes no dk/u Does the patient brush his/her teeth conscientiously?
yes no dk/u Does the patient have learning disabilities or need extra help with instructions?
yes no dk/u Is the patient sensitive or self-conscious about their teeth?

MEDICAL HISTORY

Now or in the past, has the patient had:

- yes no dk/u Birth defects or hereditary problems?
yes no dk/u Bone fractures, any major accidents?
yes no dk/u Rheumatoid or arthritic conditions?
yes no dk/u Endocrine or thyroid problems?
yes no dk/u Kidney problems?
yes no dk/u Diabetes?
yes no dk/u Cancer, tumor, radiation treatment or chemotherapy?
yes no dk/u Stomach ulcer or hyperacidity?
yes no dk/u Polio, mononucleosis, tuberculosis or pneumonia?
yes no dk/u Problems of the immune system?
yes no dk/u AIDS or HIV positive?
yes no dk/u Sexually transmitted disease?
yes no dk/u Hepatitis, jaundice or liver problems?
yes no dk/u Fainting spells, seizures, epilepsy or neurological problems?
yes no dk/u Mental health or behavioral problems?
yes no dk/u Vision, hearing, tasting or speech difficulties?
yes no dk/u Loss of weight recently, poor appetite?
yes no dk/u History of eating disorder (anorexia, bulimia)?
yes no dk/u Excessive bleeding or bruising tendency, anemia or bleeding disorder?
yes no dk/u High or low blood pressure?
yes no dk/u Tires easily?
yes no dk/u Chest pain, shortness of breath or swelling ankles?
yes no dk/u Cardiovascular problem (heart trouble, heart attack, angina, coronary insufficiency, arteriosclerosis, stroke, inborn heart defects, heart murmur or rheumatic heart disease)?
yes no dk/u Skin disorder?
yes no dk/u Frequent headaches?
yes no dk/u Frequent colds or sore throats?
yes no dk/u Eye, ear, nose or throat conditions?
yes no dk/u Hayfever, asthma, sinus trouble or hives?
yes no dk/u Tonsil or adenoid conditions?
yes no dk/u Does the patient currently have or ever had a substance abuse problem?
yes no dk/u Does the patient chew or smoke tobacco?

- yes no dk/u Operations? Describe: _____
yes no dk/u Hospitalized? For: _____
yes no dk/u Other physical problems or symptoms?
Describe: _____
yes no dk/u Being treated by another health care professional?
For: _____
Date of most recent physical exam? _____
yes no dk/u Are you in good health?

Are there any other medical conditions that we should be aware of?

- _____

yes no dk/u Are you pregnant?
yes no dk/u Are you taking birth control pills?
yes no dk/u Are you anticipating becoming pregnant?

Allergies or reactions to any of the following:

- yes no dk/u Local anesthetics (Novocaine or Lidocaine)
yes no dk/u Aspirin
yes no dk/u Ibuprofen (Motrin, Advil)
yes no dk/u Penicillin or other antibiotics
yes no dk/u Sulfa drugs
yes no dk/u Codeine or other narcotics
yes no dk/u Metals (jewelry, clothing snaps)
yes no dk/u Latex (gloves, balloons)
yes no dk/u Vinyl
yes no dk/u Acrylic
yes no dk/u Animals
yes no dk/u Foods (specify) _____
yes no dk/u Other substances (specify) _____
yes no dk/u Is the patient taking medication, nutrient supplements, herbal medications or non prescription medicine? Please name them.

Medication _____ Taken For _____
Medication _____ Taken For _____
Medication _____ Taken For _____
Medication _____ Taken For _____

FAMILY MEDICAL HISTORY

Do the patient's parents or siblings have any of the following health problems? If so, please explain.

- yes no dk/u Bleeding Disorders?

yes no dk/u Diabetes?

yes no dk/u Arthritis?

yes no dk/u Metabolic disturbances?

- yes no dk/u Severe allergies?

yes no dk/u Unusual dental problems?

yes no dk/u Jaw size imbalance?

Any other family medical conditions that we should know about?

DENTAL HISTORY

Now or in the past, has the patient had:

- yes no dk/u Primary (baby) teeth removed that were not loose?
- yes no dk/u Permanent teeth removed?
- yes no dk/u Supernumerary (extra) teeth?
- yes no dk/u Congenitally missing teeth?
- yes no dk/u Chipped or otherwise injured primary (baby) or permanent teeth?
- yes no dk/u Teeth sensitive to hot or cold; teeth throb or ache?
- yes no dk/u Jaw fractures, cysts or mouth infections?
- yes no dk/u "Dead teeth" or root canals treated?
- yes no dk/u Bleeding gums, bad taste or mouth odor?
- yes no dk/u Periodontal "gum" treatment?
- yes no dk/u Food impaction between teeth?
- yes no dk/u Thumb, finger or sucking habit? Until what age? _____
- yes no dk/u Abnormal swallowing habit (tongue thrusting)?
- yes no dk/u History of speech problems?
- yes no dk/u Mouth breathing habit, snoring or difficulty breathing?
- yes no dk/u Tooth grinding, jaw clenching, clicking or locking?
- yes no dk/u Any pain in jaw or ringing in the ears?
- yes no dk/u Any pain or soreness in the muscles of the face or around the ears?

- yes no dk/u Difficulty encountered in chewing or jaw opening?
- yes no dk/u Have you ever been treated for "TMJ" problems?
- yes no dk/u Aware of loose, broken or missing restorations (fillings)?
- yes no dk/u Any teeth irritating cheek, lip, tongue or palate?
- yes no dk/u Concerned about spaced, crooked or protruding teeth?
- yes no dk/u Aware or concerned about under or over developed jaw?
- yes no dk/u Any relative with similar tooth or jaw relationships?
- yes no dk/u "Gum Boils", frequent canker sores or cold sores?
- yes no dk/u Taking any forms of fluoride?
- yes no dk/u Any wisdom tooth problems?
- yes no dk/u Would patient object to wearing orthodontic appliances (braces) should they be indicated?
- yes no dk/u Have you ever had orthodontic treatment or worn a "retainer" or "bite plate"?
- yes no dk/u Any serious trouble associated with any previous dental treatment?
- yes no dk/u Been under another dentist's care?
Specialist _____
Other _____

I have read and understand the above questions. I will not hold Dr. Parkinson or any member of his/her staff responsible for any errors or omissions that I have made in the completion of this form. If there are any changes later to this history record or medical/dental status, I will so inform this practice.

Signature of Patient

Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I have been informed of my dental provider's *Notice of Privacy Practices*. I have been given the right to receive a full and complete copy of this office's *Notice of Privacy Practices*.

Responsible Party Printed Name

Responsible Party Signature

Date

Patient name and/or dependent family members also covered by this acknowledgement.

Please list any other individuals (i.e. spouses, ex-spouses or family members) that we can release financial or health information to:

Name: _____ Relation to Patient: _____
Name: _____ Relation to Patient: _____

Are phone messages OK? YES NO

FOR OFFICE USE ONLY

- We attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices*, but acknowledgement could not be obtained because:
- Individual refused to sign
 - Communication barriers prohibited obtaining acknowledgement
 - An emergency situation prevented us from obtaining acknowledgement
 - Other (Please specify) _____