Christopher Parkinson, DDS, MS
Orthodontic Specialist

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

Patient Information:

Child's Name:____
Last First MI

Child's Birth Date:______/______/______ Age:______ Sex: ☐Male ☐Female Common Name:______________________________

Address:____ Home Telephone #:____________________________

____
City State Zip Code

Child Attends School At:____ Grade:____________
School Name City

Hobbies and/or Sports:____

List Family Members Currently In Our Practice:
____

Parent/Guardian Information:

Mother's Name:____ ☐Step Mother ☐Guardian
Last First MI

Address:____
City State Zip Code

Home Telephone #:__________________________Work Telephone #:________________ext________Cell Phone #:________________________________

Employer:____ Social Security #:______/______/______ Driver License #:_________________ State:______

Father's Name:____ ☐Step Father ☐Guardian
Last First MI

Address:____
City State Zip Code

Home Telephone #:__________________________ Work Telephone #:________________ext________ Cell Phone #:________________________________

Employer:____ Social Security #:______/______/______ Driver License #:_________________ State:______

Who Is Responsible For Making Appointments?____
Last Name First Name

Home Telephone #:__________________________Work Telephone #:________________ext________Cell Phone #:________________________

Who Is The Primary Person Who Brings The Patient To Appointments?______________________________________
Last Name First Name

Home Telephone #:__________________________Work Telephone #:________________ext________Cell Phone #:________________________

E-mail address to receive account and appointment information:____

Financial Information:

Who Is Financially Responsible For This Account?____
Last Name First Name MI

Relationship To Patient:__________________________

Billing Address:____
City State Zip Code

Home Telephone #:__________________________Work Telephone #:________________ext________Cell Phone #:________________________________

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 Parent or Guardian **Date**

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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 your child 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?____

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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 Onset of puberty (approximate age)?______

☐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?________________

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

____

____

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?
____

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DENTAL HISTORY

Now or in the past, has the patient had:

- ☐**yes** ☐**no** ☐**dk/u** Started teething very early or late?
- ☐**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** 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** Ever had a prior orthodontic examination or treatment?
- ☐**yes** ☐**no** ☐**dk/u** Would patient object to wearing orthodontic appliances (braces) should they be indicated?
- ☐**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 Parent or Guardian **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) ____

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