PARKINSON+BUTLER ORTHODONTICS

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**

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 and Dr. Butler 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 and Dr. Butler.

_____
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 and Dr. Butler 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 and Dr. Butler.

_____
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?_____

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?

_____

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 and Dr. Butler 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)
_____