WIGAL ORTHODONTICS

Patient Information

Timothy G. Wigal, DDS, MS

Patient Information

Date _____ Nickname _____

Patient's Name _____
Last First Middle

Address _____
Street City State Zip

Home Phone _____ Birthdate _____ Age _____ Sex _____ Social Security # _____

If patient is a minor, give parent's or guardian's name _____ E-mail _____

If patient is a minor, list any siblings _____

Whom may we thank for referring you to our office? _____ Dentist _____

Responsible Party Information

Name _____ Marital Status _____
Last First Middle

Residence _____
Street City State Zip

Mailing Address _____
Street City State Zip

How long at this address _____ Home Phone _____ Work Phone _____

Cell # _____ E-mail _____

Previous Address (if less than 3 yrs.) _____
Street City State Zip

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____
Last First Middle

Residence _____
Street City State Zip

Home Phone _____ Cell Phone _____ Work Phone _____

Social Security # _____ Birthdate _____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Primary Dental Insurance

Orthodontic Coverage? ❑ Yes ❑ No

Maximum Orthodontic Coverage _____

Insurance Company _____

Insurance Co. Address _____

_____

Insurance Co. Phone _____

Group, Plan, Local or Policy # _____

Policy Holder Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Policy Holder Employer _____

Employer's Address _____

_____

Secondary Dental Insurance

Orthodontic Coverage? ❑ Yes ❑ No

Maximum Orthodontic Coverage _____

Insurance Company _____

Insurance Co. Address _____

_____

Insurance Co. Phone _____

Group, Plan, Local or Policy # _____

Policy Holder Name _____

Birthdate _____ SS# _____

Relationship to Patient _____

Policy Holder Employer _____

Employer's Address _____

_____

I understand that appropriate credit reports may be obtained and give permission for photographs to be taken which may be used for educational or promotional materials. Our office respects your privacy and will provide you with our Notice of Privacy Practices upon request.

Signature (Parent's or Guardian's signature if minor) _____ (OVER)

DENTAL & MEDICAL HISTORY

What are the main concerns you would like the Orthodontist to accomplish? _____

_____

Have you ever been evaluated or had orthodontic treatment before? . . . . . ❑ Yes ❑ No
Have there been any injuries to your face, mouth, teeth or chin? . . . . . ❑ Yes ❑ No
Do you require antibiotics before dental work? . . . . . ❑ Yes ❑ No
Have your tonsils or adenoids been removed? . . . . . ❑ Yes ❑ No
Do you have any missing or extra permanent teeth? . . . . . ❑ Yes ❑ No
Have you ever had jaw pain/tenderness in your jaw joint (TMJ/TMD)? . . . . . ❑ Yes ❑ No
Do you still have your wisdom teeth? . . . . . ❑ Yes ❑ No
Have you experienced problems with previous dental work? . . . . . ❑ Yes ❑ No
Do you brush your teeth daily? . . . . . ❑ Yes ❑ No
Do you floss your teeth daily? . . . . . ❑ Yes ❑ No
Is your water flouridated? . . . . . ❑ Yes ❑ No
Are you taking flouride supplements? . . . . . ❑ Yes ❑ No
Are your immunizations current? . . . . . ❑ Yes ❑ No
Do you play any musical instruments? . . . . . ❑ Yes ❑ No

(If yes please provide detail) _____

Did/do you have any of the following habits: (Check all that apply)

❑ Clenching/Grinding Teeth ❑ Lip Sucking/Biting ❑ Mouth Breathing ❑ Nail Biting
❑ Nursing Bottle Habits ❑ Speech Problems ❑ Thumb/Finger Sucking ❑ Tongue Thrust ❑ Used Pacifier

Are you currently under the care of a physician? . . . . . ❑ Yes ❑ No
(If yes please provide detail)

Physician's Name _____ Phone _____

Date of last visit _____ Please describe your current physical health: ❑ Good ❑ Fair ❑ Poor

Have you experienced any of the following medical problems: (Check all that apply)

❑ Abnormal Bleeding	❑ ADD/ADHD	❑ AIDS/HIV+	❑ Arthritis	❑ Artificial Joints/Valves
❑ Bleeding Gums	❑ Cancer	❑ Cerebral Palsy	❑ Chemotherapy	❑ Cold Sores/Fever Blisters
❑ Convulsions/Seizures	❑ Diabetes	❑ Difficult Breathing	❑ Dizziness or Fainting	❑ Epilepsy
❑ Frequent Colds	❑ Frequent Headaches	❑ Handicaps/Disabilities	❑ Hearing Impairment	❑ Heart Disease
❑ Heart Murmur	❑ Hemophilia	❑ Hepatitis	❑ Hospital Stays/Operations	❑ Kidney Problems
❑ Liver Disease	❑ Mitral Valve Prolapse	❑ Prosthetics	❑ Radiation Therapy	❑ Rheumatic Fever
❑ Scarlet Fever	❑ Sickle Cell Disease/Traits	❑ Sinus Problems	❑ Speech Impairment	❑ Throat Infections
❑ Thyroid Problems	❑ Tonsils/Adenoids	❑ Tuberculosis		

Allergies: ❑ Food ❑ Drug ❑ Hayfever ❑ Asthma ❑ Latex ❑ Any Metal/Jewelry ❑ Other _____

Please list any food or drug allergies that you have: _____

_____

List any drugs or medications that you are currently taking. Give reasons: _____

_____

OUR OFFICE IS HIPAA COMPLIANT AND IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC AND THE ADA.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my or my child's medical status. I authorize the Orthodontist and dental staff to perform the necessary dental/orthodontic services that I or my child may need.

We are sorry, but we cannot accept divorce decrees as assignments of responsibility for a child's orthodontic bills. The parent accompanying the child should be responsible for the services and seek reimbursement from the other parent. I, the undersigned, agree to take full responsibility for this account and agree to pay other cost of collection in the event it becomes necessary to use attorney services to secure payment of this account.

_____
SIGNATURE DATE