

## **Patient Information**

Timothy G. Wigal, DDS, MS

Patient Information ————					
Date	Nickname				
Patient's Name	First Middle				
Address	City State Zip				
Home Phone Birthdate A	.ge 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				
Residence	Mildale  City State Zip				
Mailing Address					
How long at this address Home Phone					
Cell # E-n	nail				
Previous Address (if less than 3 yrs.)					
	Relationship to Patient				
EmployerOc	cupationNo. Years Employed				
Spouse's Name	First Middle				
Residence	riist millulie  City State Zip				
	Work Phone				
Social Security # Birthdate	Birthdate Relationship to Patient				
EmployerOcc	cupation No. Years Employed				
Primary Dental Insurance	Secondary Dental Insurance —				
Orthodontic Coverage? ☐ Yes ☐ No	Orthodontic Coverage? □ Yes □ No				
Maximum Orthodontic Coverage	Maximum Orthodontic Coverage				
Insurance Company	Insurance Company				
Insurance Co. Address	Insurance Co. Address				
Insurance Co. Phone	Insurance Co. Phone				
Group, Plan, Local or Policy #	Group, Plan, Local or Policy #				
Policy Holder Name	Policy Holder Name				
Birthdate SS#	Birthdate SS#				
Relationship to Patient	Relationship to Patient				
Policy Holder Employer	Policy Holder Employer				
Employer's Address	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 co	ncerns you would like the	Orthodontist to accomp	lish?	
Have there been any Do you require antibio Have your tonsils or a Do you have any miss Have you ever had jar Do you still have your Have you experienced Do you brush your teed Do you floss your teed Is your water flouridat Are you taking flouridat Are your immunization	evaluated or had orthodon injuries to your face, mountics before dental work? Indenoids been removed? In sing or extra permanent to we pain/tenderness in your wisdom teeth? In the daily? In the daily? In the daily? In the supplements? In some current? In supplements? In	th, teeth or chin?		
(If yes please provid	e detail)			
☐ Clenching/Grinding ☐ Nursing Bottle Habits	s Speech Proble er the care of a physician	iting	er Sucking	Thrust
Physician's Name			Phone	
Date of last visit	Ple	ease describe your curre	nt physical health: 🔲 G	ood 🖵 Fair 🖵 Poor
□ Abnormal Bleeding □ Bleeding Gums □ Convulsions/Seizures □ Frequent Colds □ Heart Murmur □ Liver Disease		□ AIDS/HIV+ □ Cerebral Palsy □ Difficult Breathing □ Handicaps/Disabilities □ Hepatitis □ Prosthetics □ Sinus Problems □ Tuberculosis	☐ Arthritis ☐ Chemotherapy ☐ Dizziness or Fainting ☐ Hearing Impairment ☐ Hospital Stays/Operations ☐ Radiation Therapy ☐ Speech Impairment	☐ Rheumatic Fever
	,		•	
-	r drug allergies that you h			
List any drugs or med		ently taking. Give reaso	ns:	
OUR OFFICE IS	LUDA A COMBLIANT		ED TO MEETING O	D EVOCEDING THE

## 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