SUMMIT ORTHODONTICS

It's all about your smile!

Cassy B. Wiggins, DMD, PC

Date: _____

>>> Patient Information <<<

(confidential)

Name _____ Birth Date _____ Age _____ Home Phone _____
Address _____ City _____ Zip Code _____
E-Mail Address _____
Is the Patient (please check) Minor ○ Single ○ Married ○
Person to Contact in Case of Emergency _____ Phone _____

If Patient is a Minor—Please complete
Mother's Name _____ Address _____
Home # _____ Cell # _____ E-Mail Address _____
Marital Status _____ Employer _____ Work # _____

Father's Name _____ Address _____
Home # _____ Cell # _____ E-Mail Address _____
Marital Status _____ Employer _____ Work# _____

If Patient is an Adult—Please complete
Your Employer _____ Work # _____
Spouse's Name _____ Employer _____ Work # _____

Did your General Dentist refer you? ○ Yes If not, how did you find out about us? _____

>>> Responsible Party Information <<<

Person Responsible for this Account _____ Relationship _____
Address _____ Home # _____
Years at this address _____ Previous Address (If less than 3 years) _____
Cell # _____ E-Mail Address _____
Employer _____ Work # _____

>>> Dental Insurance Information <<<

Name of Insured _____ Relationship _____
Birth Date _____ Social Security # _____ Date Employed _____
Employer's Name _____ Work # _____
Insurance Company _____ Group # _____ Ins. ID# _____
Insurance Company Address _____
City _____ State _____ Zip Code _____ Phone # _____

IF YOU HAVE **SECONDARY DENTAL INSURANCE**, please complete the following:

Name of Insured _____ Relationship _____
Birth Date _____ Social Security # _____ Date Employed _____
Employer's Name _____ Work # _____
Insurance Company _____ Group # _____ Ins. ID # _____
Insurance Company Address _____
City _____ State _____ Zip Code _____ Phone # _____

Thank You! Please complete the back side of this form →

Patient Dental History

What are the main concerns that you would like orthodontics to accomplish?

_____
_____
_____

Has the patient ever been evaluated or had orthodontic treatment before? Yes No

Have there ever been any injuries to the face, mouth, teeth or chin? Yes No

Has the patient been informed of any missing or extra permanent teeth? Yes No

Has the patient ever had any pain/tenderness in the jaw joint? Yes No

Name of Dentist_____Phone#_____

Does the patient have any speech problems?

_____

Has the patient ever had a serious/difficult problem associated with any previous dental work? Yes No

The patient's current dental health is: Good Fair Poor

Patient Habits

Does/did the patient have any of the following habits?

Y N Clenching Teeth
Y N Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Thumb/Finger Sucking (circle one)
Y N Past habit or current habit (circle one)
Y N Tongue Thrust

Patient Medical History

Physician_____Phone #_____

Date of last visit_____

Patient's physical health is: Good Fair Poor

Is the patient under the care of a physician? Yes No

Please list all drugs that the patient is taking

_____
_____

For Women: Are you pregnant? Yes No

Has the patient ever had any of the following diseases or medical problems? Please discuss any of the marked items or any other medical problems that the patient has had in the space below.

Y N Anemia/Radiation Treatment
Y N Any Hospital Stays
Y N Any Operations
Y N Artificial Valves
Y N Arthritis
Y N Asthma
Y N Blood Transfusion
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Convulsions/Epilepsy
Y N Diabetes
Y N Drug/Alcohol Abuse
Y N Emphysema/Glaucoma
Y N Fever Blisters/Herpes
Y N Handicaps/Disabilities
Y N Heart Attack/Stroke
Y N Hearing Impairment
Y N Heart Murmur
Y N Heart Surgery/Pacemaker
Y N Hemophilia/Abnormal Bleeding
Y N Hepatitis
Y N High/Low Blood Pressure
Y N HIV+/AIDS
Y N Kidney/Liver Problems
Y N Mitral Valve Prolapse
Y N Psychiatric Problems
Y N Respiratory Problems
Y N Rheumatic/Scarlet Fever
Y N Severe/Frequent Headaches
Y N Shingles
Y N Sinus Problems
Y N Tuberculosis
Y N Ulcer/Colitis
Y N Venereal Disease
Y N Orthopedic Total Joint
Y N Any Complications w/ Orthopedic Joint

_____
_____
_____

Is the patient allergic to any of the following?

Y N Aspirin
Y N Any Metal/Plastic
Y N Codeine
Y N Dental Anesthetics
Y N Erythromycin
Y N Any Sulfa Drug
Y N Latex
Y N Penicillin or any related cillin drug
Y N Tetracycline
Y N Iodine
Y N Other

Please list any other drugs that the patient is allergic to:

_____
_____
_____
_____

Does the patient have any condition(s) requiring pre-medications?

_____
_____

Comments:_____
_____
_____
_____
_____

Authorization and Release

I certify that I have answered the above questionnaire accurately and to the best of my knowledge. I understand that providing incorrect information can be dangerous to my medical and dental health. I authorize Summit Orthodontics to release any information including the diagnosis and records of any treatment or examination rendered to the patient during the period of such orthodontic care to third party payers and/or health practitioners. I authorize and request my insurance company to pay directly to the orthodontist insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. The responsible party will be billed for services rendered in full, should the insurance company deny coverage due to non-covered benefits or lack of individual coverage. I agree to be responsible for payment of all services rendered on the patient's behalf. I understand that where appropriate, credit bureau reports may be obtained.

X_____ _____

Signature of patient (or responsible party if a minor) Date