Adult Health History/ Insurance Information

Dr. Craig B. Wiggins, D.M.D., P.S.C.

Today's Date ____-____-____.

Patients Name ______________________________ Goes by: ______________.
First MI Last

Age ______ Date of Birth ____-____-____ Gender ______ Email: ______________________

Mailing Address ______________________ City __________ State ______ Zip code ______.

Cell Phone (______) ______________ Social Security Number ____-____-______.

Dentist ______________________ Date of Last Visit ____-____-______.

Status (circle one): Married Single Divorced Separated Widowed

Spouse's Name: ______________________________ Phone # ______________________

Employer: ______________________________ How long? ______________________

Employer's address: ____

____

City State Zip Code

Emergency Contact: ____

Relation: ______________________________ Cell phone # ______________________

Primary Orthodontic Insurance Company.	Secondary Orthodontic Insurance Company.
Subscribers Name ______________________.	Subscribers Name ______________________.
Social Security No. ____-____-________.	Social Security No. ____-____-________.
Date of Birth ____-____-____.	Date of Birth ____-____-____.
ID No. ____________ Group No. __________.	ID No. ____________ Group No. __________.

Who will be the responsible party for the orthodontic contact? ______________________.

I authorize and request my insurance company to pay directly to the orthodontist insurance benefits and/or other wise be payable to me. I understand that my insurance carrier may pay less that the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf of my dependents.

______________________________ ______________________.
Signature of patient Date

CONTINUED ON NEXT PAGE

Continued Adult Health History

Dr. Craig B. Wiggins, D.M.D., P.S.C.

Reason for today's visit (circle one): Exam Emergency Consultation

Are you in pain (circle one): Yes No If so, for how long? ________________

Medications:

____

Are you currently pregnant (circle one)? Yes No N/A

Allergies:

____

Please indicate any problems you are having/have had:

- **Discomfort, clicking or popping in jaw**
- **Blisters/sores in or around the mouth**
- **Red, swollen or bleeding gums**
- **Lost/broken filling(s)**
- **Teeth grinding**
- **Ringing in ears**
- **Stained teeth**
- **Locking jaw**
- **Bad breath**
- **Broken/chipped tooth**
- **Sensitive tooth, teeth or gums**
- **Active decay/cavity(ies)**
- **Gum disease**
- **Cold/fever blisters**

Things you would change about your smile? ____

How did you hear about us? ____

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

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Signature **Date**