Health History/ Insurance Information

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

Today's Date ___ - ___ - ___.

Patients Name First MI Last **Goes by:** .

Age Date of Birth - - Sex Grade School .

Mailing Address City State Zip code .

Home Phone ( ) Social Security Number - - .

Dentist Date of Last Visit - - .

Mothers Name Occupation Employer .

Home Phone No. ( ) Work Phone No. ( ) .

Mailing Address City State Zip code .

Cell Phone ( ) Social Security Number - - .

Marital Status Email: .

Fathers Name Occupation Employer .

Home Phone No. ( ) Work Phone No. ( ) .

Mailing Address City State Zip code .

Cell Phone ( ) Social Security Number - - .

Marital Status Email: .

Primary Orthodontic Insurance Company.

Subscribers Name .

Social Security No. - - .

Date of Birth - - .

ID No. Group No. .

Secondary Orthodontic Insurance Company.

Subscribers Name .

Social Security No. - - .

Date of Birth - - .

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 (or parent/guardian if minor) **Date**

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Continued Health History

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

Explain any medical problems your child has had:

_____.

Does your child:

Have a habit of sucking a thumb, finger, lip, or other . . . . . _____.
Chew hard objects (pencils etc.) . . . . . _____.
Grind teeth . . . . . _____.
Clench jaws . . . . . _____.
Bite/Chew nails . . . . . _____.

Did mother have difficult pregnancy? _____.

Did child have any illnesses with accompanied by temperature rise of 105° or more? If so, at what age and how long. _____.

List child's illness with approximate ages:

_____.
_____.
_____.

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc)? _____.

Does your child have a history of allergies to any other substances (latex, environmental, etc)?

_____.

Are child's tonsils and adenoids present? If not when were they removed? _____.

Are there any heart, emotional, or neuro-muscular problems? If so describe.

_____.

Is your child currently taking medication? If so what please list them.

_____.

What is your child's attitude toward the following:

Dentistry . . . . . _____.
Brushing teeth . . . . . _____.
Flossing . . . . . _____.
Having orthodontic treatment . . . . . _____.

How often does your child brush their teeth? _____.

Do you feel your child would cooperate fully in orthodontic treatment? _____.

Has your child had difficulty with previous dental visits? _____.

Would you say your child is a good, average, or fair student? _____.

Has the child's mother, father, or siblings ever had orthodontic treatment? If so, who and please state their name. _____.

Has the child's mother, father, or siblings had orthodontic treatment with Dr. Wiggins? If so, who and please state their name. _____.