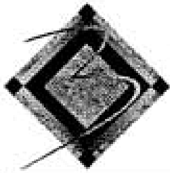

Sandy Ira Allan Bigman

◆ D.D.S., M.S.D. ◆

Diplomate,
American Board of Orthodontics

Please completely fill in the information requested on both sides of this form. A signature is required.

Patient Information

Patient's Name ______________ (Last) ______________ (First) ______________ (Middle) Male ☐ Female ☐

Address ______________ (Street) ______________ (City) ______________ (State) ______________ (Zip)

Home Phone (____) ______________ Birthdate ______________ Social Security # ______________

Patient's interests ______________ Name/Age of brothers & sisters ______________

If patient is a minor, give parent's or guardian's name ______________

Whom may we thank for referring you to our office? ______________

Responsible Party Information

A B C

Date ______________ Email ______________

Name ______________ (Last) ______________ (First) ______________ (Middle) ______________ (Marital Status)

Residence ______________ (Street) ______________ (City) ______________ (State) ______________ (Zip)

Mailing Address ______________ (Street) ______________ (City) ______________ (State) ______________ (Zip)

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

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) Relationship to Patient ______________

Employer ______________ Occupation ______________ No. Years Employed ______

Social Security # ______________ Birthdate ______________ Work Phone ______________

Dental Insurance Information

Insured Name #1 ______________	Insured Name #2 ______________
SS# of Insured ______________	SS# of Insured ______________
DOB of Insured ____ / ____ / ____	DOB of Insured ____ / ____ / ____
Employer ______________	Employer ______________
Insurance Company ______________	Insurance Company ______________
Insurance Phone No. (____) ______________	Insurance Phone No. (____) ______________
Insurance Address ______________	Insurance Address ______________
______________	______________
Insurance Group # ______________	Insurance Group # ______________

I hereby authorize release of any information to other health care providers, insurance companies, and business associates including personal health information as well as administrative data which is not strictly dental or medical in nature. I additionally authorize payment directly to Sandy Ira Allan Bigman, D.D.S. of the insurance benefits otherwise payable to me.

I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

I certify that the information on this form is complete and true to the best of my knowledge.
I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor) ______________

Updated ______________ ______________ ______________ ______________

Patient Name ______________________ Age ________ Nickname ______________ Today's Date ________

PATIENT'S MEDICAL HISTORY

Patient's Physician: Dr. ______________________ Phone ________________ City ________________

Circle Yes or No (If Yes, please fill in details)

Yes No Are you taking any medication? ________________

Yes No Are you allergic to any medication? ________________

Yes No Do you have a history of a major illness? ________________

Yes No Have you had any major operations? ________________

Yes No Have you ever been involved in a serious accident? ________________

Yes No Have you ever had your tonsils or adenoids removed? ________________

Yes No Have you ever had a concussion? ________________

Yes No Are you active in sports? If so, what sports? ________________

Circle any of the medical conditions below that you have had or currently have.

[1] Abnormal bleeding/Hemophilia
[2] Allergies/Sinus
[3] Anemia
[4] Arthritis
[5] Asthma or Hayfever
[6] Bone Disorders
[7] Congenital Heart Defect
[8] Diabetes
[9] Dizziness
[10] Epilepsy/Seizures
[11] Frequent colds
[12] Gastrointestinal Disorders
[13] Heart Murmur
[14] Heart Problems
[15] Hepatitis/Liver Problems
[16] Herpes/Oral-facial
[17] High Blood Pressure
[18] HIV/Aids
[19] Hyperactivity
[20] Immune Deficiency
[21] Kidney Problems
[22] Nervous disorder
[23] Pneumonia
[24] Radiation/Chemotherapy
[25] Rheumatic Fever
[26] Thyroid or Hormonal imbalance
[27] Tuberculosis
[28] Tumor or Cancer
[29] Ulcers
[30] Venereal disease

Are there any other medical conditions that we should be aware of? ________________

Do you have a speech problem and if so, are you receiving speech therapy? ________________

PATIENT'S DENTAL HISTORY

Dentist: Dr. ________________ Phone ______________ City ______________ Date of Last Visit ____________

What is your primary concern? ________________

Please circle

Yes No Are you presently in any dental pain? ________________

Yes No Have you ever experienced any unfavorable reaction to dentistry? ________________

Yes No Have you ever lost or chipped any teeth? ________________

Yes No Do you have any type of tongue or thumb habit? ________________

Yes No Do you breathe mostly through the mouth? ________________

Yes No Have there been any injuries to your face, mouth or teeth? ________________

Yes No Is any part of your mouth sensitive to temperature or pressure? ________________

Yes No Do your gums bleed when you brush? ________________

Yes No Do you grind your teeth at night? ________________

Yes No In the past, have you ever had: (please circle)
Clicking popping stiffness soreness in the jaw or jaw muscles?

Yes No Episodes when the jaw would not open or close normally? ________________

Yes No Pain or discomfort in the front of the ear? ________________

Yes No Have you ever experienced chronic ringing in your ears? ________________

Yes No Headaches, neck and/or back pain? ________________

If yes, please write date and details: ________________

To predict patient's growth pattern:

If the patient is under age 16, height of parents? Mom __________ Dad ______________

Female patients only: Are you pregnant? Yes No Has menstruation started? Yes No

EMERGENCY INFORMATION

Name of nearest relative not living with you ________________

Complete Address ________________

Phone ________________ Relationship ________________