Bigman Orthodontics

Changing the World, One Smile at a Time.

Specialist in Orthodontics for Children ◆ Adolescents ◆ Adults

Please completely fill in the information requested on both sides of this form.

A B C

PATIENT INFORMATION

Patient's Name _____ (Last / First / Middle)

Male ☐ Female ☐ Birthdate _____ Patient Email _____

Address _____ (Street / City / State / Zip)

Home Phone (____) _____ Work Phone (____) _____ Cell Phone (____) _____

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

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

School currently attending: _____

RESPONSIBLE PARTY INFORMATION

Email _____ Marital Status _____

Name _____ (Last / First / Middle)

Birthdate _____

Mailing Address (if different than above) _____ (Street / City / State / Zip)

How long at this address _____ Home Phone (____) _____ Work/Cell Phone (____) _____

Previous Address (if less than 3 yrs.) _____ (Street / City / State / Zip)

Employer _____ Occupation _____ No. Years Employed _____

Spouse's Name _____ (Last / First / Middle) Relationship to Patient _____

Birthdate _____ Work/Cell Phone _____

Employer _____ Occupation _____ No. Years Employed _____

DENTAL INSURANCE INFORMATION

Subscriber Name #1 _____

SS# or ID# of Subscriber _____

DOB of Subscriber ____/____/____

Employer _____

Insurance Company _____

Insurance Phone No. (____) _____

Insurance Group # _____

Subscriber Name #2 _____

SS# or ID# of Subscriber _____

DOB of Subscriber ____/____/____

Employer _____

Insurance Company _____

Insurance Phone No. (____) _____

Insurance Group # _____

I hereby authorize release of any information to other health care providers, as needed, to insurance companies, and business associates including personal health information as well as administrative data. 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.

MEMBER AAO American Association of Orthodontists

Print Name _____ **Signature** _____ **Date** _____

Updated: Print Name _____ **Signature** _____ **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 currently taking any medication? _____

Yes No Are you allergic to any food or medication? _____

Yes No Do you have a history of a major illness or accident? _____

Yes No Have you had any major operations? _____

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? _____

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

Do you have any speech problems or concerns? _____

Have you received/are you receiving speech therapy? _____

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

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

PATIENT'S DENTAL HISTORY

Dentist: Dr. _____ Phone _____ City _____ Date of Last Visit _____

Has your dentist mentioned any concerns? _____

Please circle

Yes No Are you experiencing any dental pain? _____

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

Yes No Have you ever lost or chipped any permanent teeth? _____

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

Yes No Do you breathe mostly through the mouth? _____

Yes No Do you have difficulty staying asleep at night? _____

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 or clench 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:

If the Patient is under the age of 20, height of parents? Mom _____ Dad _____

For Female patients only: Are you pregnant? Yes No

To determine growth pattern: Has menstruation started? Yes No If so, when? _____

Reviewed by Dr. Bigman

Date: _____

_____
SIGNATURE

IN CASE OF EMERGENCY PLEASE CONTACT:

Name of nearest relative/friend that we should contact in case of an emergency (within a 20 mile radius):

Name: _____ Relationship _____ Phone _____