Hingham & Duxbury Orthodontics

ABOUT YOU:

Today's Date:_____

Patient's Name:_____ (male/female)
Last First Mi

Home Tel #:_____ DOB:_____

Cell #: _____ Email: _____

Home Address:_____
Street

_____
Town State Zip

Who may we thank for referring you?_____

Other family members seen by us:_____

General Dentist:_____

_____
Street Town Zip

Tel #:_____ Last Visit:_____

SPOUSE INFORMATION:

Marital Status: single married divorced

Name:_____ Tel#:_____

Cell #:_____ Employer:_____ Work tel #:_____

EMERGENCY CONTACT:

Name:_____ Relation:_____

Tel #:_____ Cell #:_____

EMPLOYER INFORMATION:

Name:_____ Occupation:_____

Address:_____
Street Town Zip

PRIMARY DENTAL INSURANCE:

Orthodontic Coverage: YES NO

Insurance Co.:_____

Ins. Address:_____
Street Town Zip

Ins. Co. Tel #:_____ Group/Policy #:_____

Insured's Name:_____ Subscriber ID# or SS#:_____

Relation to Patient:_____ Insured's DOB:_____

Secondary Insurance: _____