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: _____

DENTAL HISTORY:

Why are you seeking orthodontic treatment for yourself?_____

Are you currently in pain? Y/N Your current dental health is: Good Fair Poor

Have you ever had a serious/difficult problem associated with previous dental work? Y N

Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)? Y N

Do your gums ever bleed? YES NO How many times a week do you floss?_____

How many times a day do you brush?___ Types of bristles? Hard Medium Soft

MEDICAL HISTORY:

Do you have a personal physician? Y/N Name:_____

Tel #:_____ Last Visit:_____

Your current physical health is: Good Fair Poor Are you taking any prescription drugs? Y N

Are you currently under the care of a doctor? Y/N Explain:_____

FOR WOMEN ONLY:

Are you taking birth control pills? Y/N Are you pregnant? Y/N Are you nursing? Y/N

HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES OR MEDICAL PROBLEMS?:

Prothesis	Y	N	History of Scarlet Fever	Y	N
Heart Attack	Y	N	Congenital Heart Def.	Y	N
Cancer	Y	N	Convulsions/Epilepsy	Y	N
Diabetes	Y	N	Abnormal Bleeding	Y	N
Rheum. Fev.	Y	N	Artificial Valves	Y	N
HIV +/ AIDS	Y	N	Heart Surgery/Pacmkr.	Y	N
Hemophilia	Y	N	Any Stays in Hospital	Y	N
Asthma	Y	N	Kidney/Liver Problems	Y	N
Hepatitis	Y	N	Mitral Valve Prolapse	Y	N
Tuberculosis	Y	N	Artificial bones/joints	Y	N
Shingles	Y	N	Sev./Freq. Headaches	Y	N
Fever blister	Y	N	Hi/Lo blood pressure	Y	N
Venereal Dis.	Y	N	Drug/Alcohol Abuse	Y	N
Ulcers/Colitis	Y	N	Blood Transfusion	Y	N
Heart Murm.	Y	N	Anemia/Radiation tmt.	Y	N
Emphysema	Y	N	Glaucoma	Y	N
Sinus Probs.	Y	N	Difficulty Breathing	Y	N

Other:_____

Are you **allergic** to any drugs?:_____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my medical status. I also authorize the dental staff to perform the necessary dental services I may need during treatment.

_____

Signature Date

In accordance with the federal government HIPAA rules, please sign below to acknowledge you have received a copy of Paul Fitzgerald D.M.D., P.C.'s Notice of Privacy Practices.

_____

Signature Date