Bedford Orthodontics

Orthodontics for children and adults

WELCOME TO BEDFORD ORTHODONTICS!

Please assist us in answering the following (complete in blue or black ink):

Patient Information			
	Patient's Name:	Nickname:	
	Date of Birth:	Age:	Gender: M / F / Non-Binary
	Address:	City:	State/Zip:
	Cell Phone:	Home:	Work:
	If patient is a minor, give parent or guardian names:		
	Who may we thank for referring you to our office?:		
	Family Dentist:	Physician:	
	School:	City:	Grade:
	Hobbies:	Siblings (ages):	

Responsible Party			
	First and Last Name:		Marital Status:
	Relation to Patient:	Spouse's Name:	
	Preferred Contact Method:	Email Address:	
	Address:	City:	State/Zip:
	Cell Phone:	Home:	Work:

Dental Insurance			
	Full Name of Subscriber:		Subscriber DOB:
	Subscriber ID# or SSN:		Relation to Patient:
	Employer:	Occupation:	
	Insurance Company:	Group #:	
	Insurance Company Address:		
	Insurance Company Phone:		
	*** Please inform the Front Desk if you have additional dental insurance ***		

RELEASE

I assign all insurance benefits otherwise payable to me to Bedford Orthodontics. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature: _____ **Date:** _____

RICHARD M. HESBY, D.D.S., M.S.

55 NORTH ROAD, SUITE 215 BEDFORD, MA 01730

T 781.275.0575 F 781.275.0577

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Reason for visit? (i.e., referred by dentist, crowding, appearance, etc.)	
Name of Family Dentist:	Did he/she refer you to our office?
Date of last dental cleaning (month/year):	Was a panoramic x-ray taken?
Has the patient previously been seen by another orthodontist, or had any prior orthodontic treatment? If yes, please describe:	
Any problems with previous dental or orthodontic treatment? If yes, please explain:	
Has the patient's physician prescribed antibiotics before dental procedures? If yes, please explain:	
Does anyone else in the family have a similar dental need? If yes, please describe:	
Has anyone in family received orthodontic treatment? If yes, how did they feel about the result?	
Is the patient sensitive or self-conscious about his/her teeth?	
Is the patient aware of any of the following conditions? ☐ Y ☐ N Clenching or grinding teeth? ☐ Y ☐ N Clicking, popping or grating noise in your jaw joint? ☐ Y ☐ N Discomfort, tightness or spasms of facial or neck muscles? ☐ Y ☐ N Catching or locking of the jaw? ☐ Y ☐ N Has patient ever injured neck, head or jaw? ☐ Y ☐ N Has patient ever injured or damaged any teeth? ☐ Y ☐ N Was/is there any thumb or finger sucking? Until what age? _____ ☐ Y ☐ N Difficulty breathing through nose?	

I affirm that the information I have given is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes in medical status. I understand that Orthodontics is a dental specialty dealing with the alignment of the teeth and jaw, and is different from General Dentistry. I also understand that good oral hygiene and regular visits at a minimum of every 6 months to my General Dentist are critical to maintaining dental health before, during and after orthodontic treatment.

Signature of Patient or Guardian _____ **Date** _____
(if patient is a minor)

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Date of Last Physical Exam (month/year):	Name of Physician:
Is patient currently under the care of a physician? ☐ **Yes** ☐ **No** If **yes,** please explain:	
Has patient been hospitalized in the past 5 years? ☐ **Yes** ☐ **No** If **yes,** please explain:	
Is patient currently taking any medications? ☐ **Yes** ☐ **No** If **yes,** please list:	
Has patient's tonsils or adenoids been removed? ☐ **Yes** ☐ **No** If **yes,** please explain:	
Height of Patient's Biological Father:	Height of Patient's Biological Mother:

Are there any behavioral or emotional conditions or problems that Dr. Hesby should be aware of to better serve you/your child?

☐ ADHD/ADD ☐ Autism Spectrum Disorder ☐ Anxiety Disorder ☐ Sensory Disorder
☐ Other: _____ ☐ None

Have you had or do you have any of the following?

☐ Y ☐ N Heart problems/Disease
☐ Y ☐ N Heart Murmur
☐ Y ☐ N High/Low Blood Pressure (circle one)
☐ Y ☐ N Stroke/Circulatory Problems
☐ Y ☐ N Bleeding problems/Hemophilia
☐ Y ☐ N Anemia
☐ Y ☐ N Pacemaker
☐ Y ☐ N Nervous System Problems
☐ Y ☐ N Epilepsy/Seizures
☐ Y ☐ N Musculoskeletal Disorders
☐ Y ☐ N Measles/Mumps (circle one)
☐ Y ☐ N Rheumatic Fever
☐ Y ☐ N Scarlet Fever
☐ Y ☐ N Tuberculosis
☐ Y ☐ N Allergies to Medications: _____
Other allergies: _____

☐ Y ☐ N Arthritis/Joint Problems
☐ Y ☐ N Asthma
☐ Y ☐ N Typhoid Fever
☐ Y ☐ N Diabetes
☐ Y ☐ N Ulcers/Acid Reflux
☐ Y ☐ N Hepatitis
☐ Y ☐ N HIV/AIDS
☐ Y ☐ N Malignancies/Cancer
☐ Y ☐ N Osteoporosis/Bone Problems
☐ Y ☐ N Artificial Joints/Transplants
☐ Y ☐ N Liver Problems/Disease
☐ Y ☐ N Speech Problems
☐ Y ☐ N Sinus Problems
☐ Y ☐ N Tonsilitis
☐ Y ☐ N Learning Disabilities
☐ Y ☐ N Psychiatric Problems
☐ Y ☐ N Other: : _____

Please discuss with Dr. Hesby any family circumstances, school situations, medical or psychological problems not covered above that may affect treatment.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

(Please Print Parent/Guardian Name)

_____

Signature

_____

Date

_____

Patient Name

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

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