

**DATE:**

<b>Patient Information</b>	
Patient Name:	Preferred Name:
Birthdate:	Age: Male / Female
Address:	Phone #:
Dentist:	Date Last Visit:
Physician:	Date Last Visit:
Parent/Guardian with Patient today:	
How did you hear of our office?	

<b>Health/Dental Information</b>			
<i>The following information will help us give the patient a thorough orthodontic consultation</i>			
	<b>Check One</b>	<b>YES</b>	<b>NO</b>
1. Does the patient have a health problem?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Is the patient under treatment by a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Is the patient currently taking any medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Does the patient have any allergies or sensitive to any medication?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the patient ever been hospitalized?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has anyone in the family had Hepatitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Has the patient had any history of the following? (if yes please circle)			
Heart trouble or Congenital Heart Lesions	Diabetes		
Asthma	Heart Murmur		
Skin Rash or Hives	Rheumatic/Scarlet Fever		
Kidney Involvement	Blood disorders/Hemophilia		
Hepatitis or Liver Involvement	Nervousness		
Epilepsy	Blood Transfusion		
Cold Sores or Fever Blisters	Thyroid Abnormalities		
Tuberculosis	HIV/AIDS		
Fainting or Dizziness	Other: _____		
8. Has the patient ever had a thumb sucking habit?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Has the patient had previous orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Have other family members had orthodontic treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Have other family members been to this office for a consult?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Will the patient be moving from SLO County within the next three years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

<b>Emergency Information</b>				
Name of nearest relative not living with you:				
Complete Address:				
	Street	City	State	Zip
Phone:				

<b>Acknowledgement of HIPPA Privacy Practices</b>	
I hereby acknowledge that I am aware of the HIPPA Notice of Privacy Practice Act and that we are required to provide you with a copy upon request.	
Print Name: _____	Signature: _____
Relationship to Patient: <input type="checkbox"/> Self <input type="checkbox"/> Parent/Guardian	
FOR OFFICE USE ONLY: We have made every effort to obtain written acknowledgement of receipt of our Notice of Privacy from this patient but it could not be obtained for one of the following reasons: patient refused to sign, an emergency inhibited ability to obtain, not able to communicate w/patient.	
	Employee Signature: _____

### Responsible Party Information

Name:		Relation to Patient:	
Address:			
Mailing Address if Different:			
Number of Years at this Address?		Previous Address (if less than 3 yrs):	
Birthdate:		SS#:	
Best Contact #:		Alternate Contact #:	
Cell Phone if Different:		<b>Email:</b>	
Work #:			
Occupation:		Employed by:	How Long?
Marital Status:			
Spouse/Partner Name:		SS#	Relation to Patient:
Best Contact #:		Alternate Contact #:	
Occupation:		Employed by:	How Long?
<i>I understand that, where appropriate, credit bureau reports may be obtained.</i>			
<b>Signature:</b>			

### Dental Insurance Information

Insured's Name:		SS#:	Birthdate:
Insurance Co Name:		Phone #:	
ID # (as appears on card):		Group #:	
Do you have additional dental insurance through another insured?			
Insured's Name:		SS#:	Birthdate:
Insurance Co Name:		Phone #:	
ID# (as appears on card):		Group #:	
<i>_____ (initial) I understand that I am responsible for researching and understanding my insurance benefit coverage. I understand that no guarantee of payment from my insurance company has been made and that any balance owed is my responsibility.</i>			

### AUTHORIZATION FOR TREATMENT AND USE OF RECORDS

I authorize that all necessary Orthodontic treatment be given. This includes taking impressions, a bite registration and diagnostic photos. When appropriate, Dr. Daniel may use these records for teaching purposes at accredited schools or lecture events.

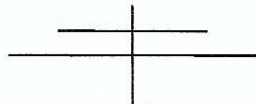
Signature: \_\_\_\_\_

Date: \_\_\_\_\_

#### For Office Use Only

CC:

Exam:



Profile:

TMJ:

	FULL TX
	PHI
	INV
	LTD
	RCL

Perio:

X-bite:

1\*teeth present:

missing:

Crowding / Spacing: max:

mand:

Class:

OJ:

OB:

Proposed:

Est. Fee:

Next Visit: