Frank J. Daniel, D.M.D.
American Board of Orthodontics

DATE:

Patient Information

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?		

Health/Dental Information

The following information will help us give the patient a thorough orthodontic consultation

	Check One YES	NO
1. Does the patient have a health problem?	☐	☐
2. Is the patient under treatment by a physician?	☐	☐
3. Is the patient currently taking any medication?	☐	☐
4. Does the patient have any allergies or sensitive to any medication?	☐	☐
5. Has the patient ever been hospitalized?	☐	☐
6. Has anyone in the family had Hepatitis?	☐	☐

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?	☐	☐
9. Has the patient had previous orthodontic treatment?	☐	☐
10. Have other family members had orthodontic treatment?	☐	☐
11. Have other family members been to this office for a consult?	☐	☐
12. Will the patient be moving from SLO County within the next three years?	☐	☐

Emergency Information

Name of nearest relative not living with you:			
Complete Address:			
Street	City	State	Zip
Phone:			

Acknowledgement of HIPPA Privacy Practices

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: ☐ Self ☐ 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:	**Email:**		
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 understand that, where appropriate, credit bureau reports may be obtained. **Signature:**			

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 #:	
_____***(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.*		

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:

Perio:

X-bite:
1*teeth present:
missing:
Crowding / Spacing: max:
mand:
Class:

Profile:

TMJ:

OJ: OB:

Proposed:

- ☐ FULL TX
- ☐ PH1
- ☐ INV
- ☐ LTD
- ☐ RCL

Est. Fee:
Next Visit: