Explore
ORTHODONTICS
KAY DANIEL, DDS
SPECIALIST IN ORTHODONTICS

Date _____

Patient Full Name _____ Date of Birth _____

❑ Male ❑ Female Patient's SSN _____ Nickname (if applicable) _____

Patient's Email Address _____ Patient's Cell Phone _____

Address _____ Home # _____

City _____ State _____ Zip Code _____

Patient Resides With: (Please Circle) Both Parents Mother Father Other/Self

Employer or if Full Time Student, School _____

Whom may we thank for referring you? _____

Please let us know of any other family members seen by Dr. Kay Daniel _____

DENTAL / MEDICAL HISTORY

General Dentist _____ Date of Last Cleaning _____

Is there still work to be done from last dental check up? (Please List) _____

Chief dental / orthodontic complaint: _____

Does the patient have:

1. Pain / clicking in the jaw joint: (Please Circle) Usually Sometimes Never
2. A bite that feels "uncomfortable or unusual" Yes No
3. Any teeth injured due to accident Yes No

If yes, please explain: _____

The following habits are of interest Please list age the habit was broken:

Thumb Sucking _____ Grinding Teeth _____ Lip biting or sucking _____

Finger Sucking _____ Clenching Teeth _____ Tongue thrusting _____

☐ IF PATIENT IS A CHILD OR PARENT IS RESPONSIBLE PARTY

Parent / Guardian Martial Status: (Please Circle) Single Married Divorced

Mother's (Guardian) Name _____ **SS#** _____

Address _____ Phone # _____

City _____ State _____ Zip Code _____

Employer _____ Work # _____

Email Address _____ Cell Ph # _____

Father's (Guardian) Name _____ **SS#** _____

Address _____ Phone # _____

City _____ State _____ Zip Code _____

Employer _____ Work # _____

Email Address _____ Cell Ph # _____

If the child's guardian is not the natural parent, please give relationship: _____

INSURANCE INFORMATION

Policy Holder's Name _____ Relation to Patient _____

Insured's Date of Birth _____ SS# _____

Insured Employer _____ Insured's Member or ID # _____

Insurance Company _____ Insurance Phone _____

☐ ***Additional / secondary insurance information listed on reverse***

ORTHODONTIC HISTORY

Has the patient had a previous orthodontic consultation? (Please Circle) Yes No

Has the patient had previous orthodontic treatment? (Please Circle) Yes No

If yes to either, date_____ Doctor_____

Medical History

Physician Name _____

Is the patient pregnant or possibly pregnant YES NO

Is the patient allergic to _____ **LATEX** _____ **MEDICATIONS, IF SO, WHAT?** _____

Has the patient ever had (Please check all that apply)

_____Arthritis	_____ Bone Disorders	_____ Heart Disease	_____Endocrine Problems
_____Anemia	_____ Cold Sores	_____ Head/Face Injury	_____Heart Murmur
_____Asthma	_____ Diabetes	_____ Hearing Disorders	_____Thyroid Problems
_____Birth Defects	_____ Epilepsy	_____ Herpes	_____Kidney Disease
_____Blood Disease	_____ Hepatitis	_____ Rheumatic Fever	_____Lung Disease
_____HIV/AIDS	_____ Oral Ulcers	_____ Previous Surgery	_____Mitral Valve Prolapse

Has the patient ever been diagnosed with any other medical / behavioral / mental condition? (If yes please list)

_____Autism Spectrum	_____ Emotional Disorder	_____ Depression / Bi-Polar Disorder
_____ADD/ADHD	_____ Behavioral Disorder	_____ Anxiety / Nervous Disorder

Other / Comments_____

_____

If the patient has been under the care of a physician during the last two years for anything other than routine exams, please explain _____

_____

Present drugs or medication _____

RESPIRATORY HISTORY

Does the patient have: (Please check all that may apply)

1. Allergies:	☐ Seasonal	☐ Food	Other _____
2. Breath through mouth:	☐ Usually	☐ Sometimes	☐ Never
3. Snore when sleeping:	☐ Usually	☐ Sometimes	☐ Never
4. Frequent colds:	☐ Usually	☐ Sometimes	☐ Never
5. Frequent stuffy nose:	☐ Usually	☐ Sometimes	☐ Never
6. Frequent sore throat / tonsillitis:	☐ Usually	☐ Sometimes	☐ Never
7. Difficulties chewing / swallowing:	☐ Usually	☐ Sometimes	☐ Never

8. Received medical treatment from an allergist or ear, nose, and throat specialist: YES NO

If yes, when_____ By Whom_____

☐ Nasal Surgery ☐ Tonsils Removed ☐ Adenoids Removed

AUTHORIZATION & RELEASE

I certify the above information is correct and complete. I understand that providing incorrect or incomplete information can be dangerous to this patient's health. I agree to be responsible for payment of all services rendered including what is billed to my insurance company. I authorize my insurance company to pay benefits directly to Dr. Daniel's office. I understand information will be communicated with anyone who accompanies this patient to appointments. I also authorize Dr. Daniel and her staff to perform any form of treatment, medication, or therapy regarding this patient.

_____ _____

Patient / Parent / Guardian Printed Name and Relationship to Patient