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 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: _____

☐ 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***

I certify the above information is correct and complete. 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