Welcome To UNIQUE ORTHODONTICS

PLEASE COMPLETE AND RETURN UPON CONSULTATION VISIT

Today's Date
Email Address (parent/guardian)
Who is your DENTIST? Address: Phone: Last Visit:
Who may we THANK for referring you?
Do you have other family members seen by us?

a. Please Tell Us About Yourself

First Name
Last Name
Age DOB M / F
SS#
Residence Street Apt City State Zip
Mailing Address – if different Street Apt City State Zip
How long at this address?
Previous Address – if applicable Street Apt City State Zip
Home Phone
Cell Phone
Work Phone

b. Please Tell Us About Your Employer

Name
Your Title
How long have you worked there?
When and where are the best times to reach you?
Address Street Apt City State Zip

c. Spouse Information

First Name
Last Name
Employer
Work Phone
Cell Phone
SS#

Please fill out if different than your information

Residence Street Apt City State Zip

d. Dental Insurance

Ins. Name	Group/Policy #	Ins. Address
Insured's Name		Relationship to Patient
Insured's DOB	Insured's SS#	Employer

Health History

Dental History

Do you like your smile? O Yes O No

Why have you come to the orthodontist today?

Your current dental health is: O Good O Fair O Poor

How many times a week do you floss? ____________________________

How many times a day do you brush? ____________________________

Types of bristles? Hard Medium Soft

Are you currently in pain? O Yes O No

Have you ever had an injury to the jaw/teeth/chin/mouth? O Yes O No

Have you ever been evaluated by an Orthodontist? O Yes O No

Have you ever had a serious/difficult problem with previous dental work? O Yes O No

Do your gums ever bleed? O Yes O No

Have you ever had any pain or tenderness in the jaw joint (TMJ/TMD)? O Yes O No

Health History

Have you ever taken PHEN-FEN or REDUX? O Yes O No

Do you have a personal physician? O Yes O No

Name Phone Last Visit

Are you currently under the care of a doctor? O Yes O No

If applicable, explain:

Are you taking any prescription drugs? O Yes O No

If applicable, explain:

Have you ever had any of the following medical problems?

O Yes O No Heart Murmur

O Yes O No High/Low Blood Pressure
O Yes O No Heart Surgery/Pacemaker
O Yes O No Mitral Valve Prolapse
O Yes O No Cancer/Chemo/Therapy
O Yes O No Diabetes
O Yes O No Rheumatic Fever
O Yes O No Hemophilia
O Yes O No Abnormal Bleeding
O Yes O No Asthma
O Yes O No Sinus/Breathing Problems
O Yes O No Arthritis
O Yes O No Adenoid/Tonsil Removal

O Yes O No Artificial Bones/Joints
O Yes O No Hepatitis
O Yes O No Tuberculosis
O Yes O No Congenital Heart Disease
O Yes O No Convulsion/Epilepsy
O Yes O No Seizures/Fainting Spells
O Yes O No Hearing Impairment
O Yes O No Any Operations
O Yes O No Any Stays in Hospital
O Yes O No Kidney/Liver Problem
O Yes O No Handicaps/Disabilities
O Yes O No Psychiatric Problems
O Yes O No Learning Problems
O Yes O No Speech Problems

O Yes O No HIV+/AIDS
O Yes O No History of Scarlet Fever
O Yes O No Allergies to Any Drugs

Our office is committed to meeting or exceeding standards of infection control mandated by OSHA, the CDC and the ADA.

Please discuss any serious medical problems you have had below:

For Women Only	Are you taking birth control pills?	O Yes O No
	Are you pregnant?	**O Yes O No Week #: ______________**
	Are you nursing?	O Yes O No

Are you aware of any allergies you may have?

Aspirin/Codeine	O Yes O No
Latex/Rubber Gloves	O Yes O No
Penicillin/ Tetracycline/Erythromycin/Sulfa	O Yes O No
Any Metals/Plastics	O Yes O No
Dental Anesthetics	O Yes O No
General Anesthetics	O Yes O No

Please list other ALLERGIES not mentioned above

Emergency Contact Information

Name of Person to Contact in Case of Emergency	
Address Street State Zip	
Primary Phone Home / Work/ Cell	Secondary Phone Home / Work/ Cell

- ✓ **I understand that I am responsible for payment of services rendered, and Unique Orthodontics will bill my Insurance Company for all services rendered including X-rays. I allow this office to use my name on documents submitted to my insurance.**
- ✓ **I authorize dental benefits through my employment that might otherwise be payable to me, to be paid to this office.**
- ✓ **This office reserves the right, when appropriate, to verify credit status of potential patients and/or parents prior to extending credit for treatment fees, and may use the services of one or more credit reporting agencies.**
- ✓ **I understand the information that I have given and acknowledge that the questions I have answered are correct to the best of my knowledge, that I will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status.**
- ✓ **I also authorize the dental staff to perform the necessary dental services my child may need.**

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Signature Date

PLEASE NOTE: The parent/guardian who accompanies this child is responsible for payment at time of services unless prior arrangements have been approved.

Office Use Only ~ Office Use Only ~ Office Use Only ~ Office Use Only

I verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.	Initial: Date:	Doctor's Comments	
1. Medical History Update Comments		Date	Signature
2. Medical History Update Comments		Date	Signature