UNIQUE ORTHODONTICS

New Patient Registration

Patient Information

Full Name _____

Date of Birth _____ Age _____

Address _____ Apt _____

City _____ State _____ Zip Code _____

Social Security Number _____ Gender ____

Phone _____ Email _____

Employer Name _____

Responsible Party (if different from patient)

Full Name _____

Date of Birth _____ Age _____

Address _____ Apt _____

City _____ State _____ Zip Code _____

Social Security Number _____ Gender ____

Phone _____ Email _____

Employer Name _____

Preferred Language _____

Dental Insurance Information

Primary Insurance Name _____

Subscriber Name _____ DOB _____

Subscriber Employer _____

Subscriber ID/SS # _____ Group No. _____

Patient's Relationship to subscriber ☐ Self ☐ Spouse ☐ Child

Does the subscriber live in the same household? ☐ Yes ☐ No

Secondary Insurance Name _____

Subscriber Name _____ DOB _____

Subscriber Employer _____

Subscriber ID/SS # _____ Group No. _____

Patient's Relationship to subscriber ☐ Self ☐ Spouse ☐ Child

Does the subscriber live in the same household? ☐ Yes ☐ No

Emergency Contact

Name _____ Relationship _____

Phone _____

Patient Medical Information

Physician Name _____

Address _____

Phone _____ Fax _____

Date of Last Physical Exam _____

1. Are you currently under the care of a physician? ☐ Yes ☐ No

If yes, please explain _____

2. Are you currently taking prescription medications? ☐ Yes ☐ No

If yes, name of medication(s) _____

3. Are you being treated for any medical condition? ☐ Yes ☐ No

4. Have you ever had or been exposed to Tuberculosis? ☐ Yes ☐ No

5. Have you ever taken Phen-Fen or Redux? ☐ Yes ☐ No

6. Have you ever taken bisphosphonates? ☐ Yes ☐ No
(Fosamax, Boniva)

7. Are you currently taking blood thinners? ☐ Yes ☐ No
(Warfarin, Eliquis, Plavix)

Patient Allergies

8. Are you allergic to or had a reaction to aspirin? ☐ Yes ☐ No

9. Are you allergic to or had a reaction to Latex? ☐ Yes ☐ No
(rubber/plastic)

10. Are you allergic to or had a reaction to antibiotics? ☐ Yes ☐ No
(Penicillin, Tetracycline, Erythromycin, Sulfa)

11. Are you allergic to or had a reaction to metals? ☐ Yes ☐ No
(nickel, zinc, chromium, cobalt, copper)

12. Are you allergic to or had a reaction to anesthetics? ☐ Yes ☐ No
(local, general, dental)

13. Are you allergic to or had a reaction to codeine? ☐ Yes ☐ No
(barbiturates, sedatives or other narcotics)

14. Are you allergic to or had a reaction to any food? ☐ Yes ☐ No
(nuts, milk, etc.)

15. Any other allergic reactions or sensitivities? ☐ Yes ☐ No

Patient Recreational Use

Do you use tobacco or vaping products? ☐ Yes ☐ No

Do you use marijuana or other substances? ☐ Yes ☐ No

Do you consume alcohol? ☐ Yes ☐ No

For Female Patients Only (if applicable)

16. Are you pregnant or think you may be pregnant? ☐ Yes ☐ No

Patient Name: **Date:**

Please indicate whether you have ever had any of the following conditions/symptoms by marking YES or NO. Accurate responses help us provide safe and effective orthodontic care.

Condition / Symptom	YES	NO	Oral & Maxillofacial	YES	NO
17. ADD / ADHD	☐	☐	43. Oral Surgery	☐	☐
18. Arthritis	☐	☐	44. Cleft Lip and/or Palate	☐	☐
19. Artificial Bones /Joint	☐	☐	45. Injury to Face, Jaw, Teeth, or Mouth	☐	☐
20. Asthma / Emphysema	☐	☐	46. Jaw Pain, Locking, Popping, Dislocation (TMJ/TMD)	☐	☐
21. Autism Spectrum Disorder	☐	☐	Oral Habits		
22. Bleeding Disorders	☐	☐	47. Thumb, Finger, or Object Sucking	☐	☐
23. Birth / Congenital Defects	☐	☐	48. Lip, Cheek, Nail, or Object Biting	☐	☐
24. Cancer (Chemo/Radiation)	☐	☐	49. Mouth Breathing	☐	☐
25. Convulsion / Epilepsy	☐	☐	50. Teeth Grinding or Clenching (Bruxism)	☐	☐
26. Diabetes (Type: _____)	☐	☐	50. Tongue Thrusting / Lisp	☐	☐
27. Developmental Disabilities	☐	☐	51. Speech Problems / Speech Therapy	☐	☐
28. Headaches / Migraines	☐	☐	Dental Health		
29. Hepatitis (Type: _____)	☐	☐	52. History of oral cancer	☐	☐
30. Herpes	☐	☐	53. Sores, Lumps, or Lesions in Mouth	☐	☐
31. HIV / AIDS	☐	☐	54. Persistent Bad Breath (Halitosis)	☐	☐
32. High / Low Blood Pressure	☐	☐	55. Enlarged Tonsils	☐	☐
33. Heart Surgery / Pacemaker	☐	☐	56. Cold Sores, Ulcers, or Blisters	☐	☐
34. Hemophilia	☐	☐	57. Do your gums Bleed, swollen, red, or are painful	☐	☐
35. Hearing Impairment	☐	☐	58. Current Dental Appliances (Fixed or Removable)	☐	☐
36. Kidney / Liver Problems	☐	☐	59. Have you had any dental restorations	☐	☐
37. Learning Disabilities	☐	☐	60. Loose Teeth	☐	☐
38. Osteoporosis / Osteopenia	☐	☐	61. Extra (Supernumerary) Teeth	☐	☐
39. Mental Health Conditions	☐	☐	62. Broken or Chipped Teeth	☐	☐
40. Seizures	☐	☐	63. Are you missing any teeth	☐	☐
41. Stroke / Heart Attack	☐	☐	64. Sensitivity to Sweets	☐	☐
42. Thyroid (Hype / Hypo)	☐	☐	65. Sensitivity to Hot or Cold	☐	☐

Cavity Clearance

Dentist Name: _____ Phone: _____ Fax _____

Address: _____

Date of Last Dental Exam: _____ Date of Last Dental Cleaning: _____ Date of Last Dental X-rays: _____

Do you have any pending dental treatment? _____ Are you experiencing any pain or discomfort in your teeth, mouth, or jaw? _____

Do you require premedication prior to any dental procedure? ☐ Yes ☐ No

Do you require medical clearance from your provider or specialist before dental treatment? ☐ Yes ☐ No

How often do you brush your teeth? _____ How often do you floss your teeth? _____

Orthodontic History

Have you been evaluated by an orthodontist? ☐ Yes ☐ No

Have you ever received orthodontic treatment (braces, aligners, etc.)? ☐ Yes ☐ No

Are you currently undergoing orthodontic treatment or wearing retainers? ☐ Yes ☐ No

If yes, please provide the orthodontist's name: _____ Date braces/aligners were placed: _____

Have you or any family member previously received care at any Unique Orthodontics location? ☐ Yes ☐ No

If yes, please provide the name(s) and location(s): _____

Referral Source

How did you hear about Unique Orthodontics?

☐ Airport Advertisement ☐ Billboard	☐ Google or Yelp ☐ Facebook, Instagram, X, TikTok	☐ Spotify or Pandora ☐ Unique Orthodontics Website	☐ Friend or Family Referral ☐ Word of Mouth

Consent, Financial Responsibility & Authorizations

I consent to receive appointment reminders and treatment-related communications, including billing information, by phone call, voicemail, text message (SMS), and/or email at the contact information I have provided. I understand that text messages and unencrypted email communications may not be secure and may carry some risk of unauthorized access. Message and data rates may apply. I understand that I may revoke or modify my communication preferences at any time by notifying the office in writing.

I understand that I am financially responsible for all services rendered, regardless of insurance coverage. As a courtesy, Unique Orthodontics will submit insurance claims on my behalf. I authorize payment of insurance benefits directly to Unique Orthodontics. I understand that I am responsible for any balance not paid by my insurance carrier, including deductibles, co-payments, co-insurance, and non-covered services.

If credit or a payment plan is extended, I authorize Unique Orthodontics to obtain and verify credit information of the responsible parent or legal guardian in accordance with applicable federal and California laws, including the Fair Credit Reporting Act (FCRA).

I authorize the orthodontist and clinical staff to perform examinations, diagnostic procedures, radiographs, as deemed necessary or advisable for my care.

I authorize the taking of photographs, digital images, radiographs, and/or video recordings for purposes of diagnosis, treatment planning, identification, quality assurance, and healthcare operations.

I certify that the information I have provided is accurate and complete to the best of my knowledge.

Patient Name: _____ **Signature:** _____ **Date:** _____

Parent/Legal Guardian Name: _____ **Signature:** _____ **Date:** _____

Orthodontist Name: _____ **Signature:** _____ **Date:** _____

Smile Goals & Orthodontic Consultation Questionnaire

At Unique Orthodontics, we believe a confident smile can positively impact your health, confidence, and future. Please take a few moments to help us understand what matters most to you.

What motivated you to schedule today's consultation?

(Select all that apply)

☐ I am unhappy with my smile ☐ I would like more confidence when I smile ☐ A family member or friend recommended treatment ☐ I don't like how my teeth look in photos ☐ I have a big event coming up (wedding, senior, or prom pictures)	☐ Spacing between teeth ☐ Crowding (overlapping teeth) ☐ My general dentist recommended orthodontic treatment ☐ Jaw discomfort or bite problems ☐ Other: _____

How confident are you in your smile today? 1 2 3 4 5 6 7 8 9 10
(Circle one)

If we could improve one thing about your smile, what would it be? _____

How often do you think about improving your smile? ☐ Rarely ☐ Occasionally ☐ Often ☐ Daily	How long have you been considering orthodontic treatment? ☐ 0–6 months ☐ 6–12 months ☐ 1–2 years ☐ 3–5 years

Which treatment options are you interested in learning more about?
(Select all that apply)

☐ Traditional Metal Braces ☐ Clear (Ceramic) Braces ☐ Self-Ligating Braces	☐ Clear Aligners (Invisalign®-type treatment) ☐ Early/Phase I Treatment (for children) ☐ Not sure – I would like the doctor's recommendation

What matters most to you? ☐ Fast results ☐ Discreet appearance ☐ Comfort ☐ Affordable payments

Understanding your preferences helps us customize payment options.

Have you reviewed your orthodontic insurance benefits? ☐ Yes ☐ No ☐ Unsure

Which payment approach feels most comfortable? ☐ Insurance + Monthly Payments ☐ Flexible In-House Monthly Plan ☐ Pay in Full (if discount applies) ☐ I'd like help choosing the best option	If affordable monthly payments are available, would you be ready to begin treatment? ☐ Yes ☐ Maybe ☐ I would like to discuss options ☐ Not at this time	Are you prepared to make a down payment today if we create a financial plan that works for you? ☐ Yes ☐ Possibly, depending on amount ☐ I would like to discuss options ☐ Not at this time

Is there anyone else involved in the financial or treatment decision? ☐ No I am the decision maker ☐ Yes (Name/Relationship): _____

PARENT / GUARDIAN SECTION (If Patient is a Minor)

What is your top priority for your child's orthodontic treatment?

☐ Oral Health ☐ Bite/Function Improvement ☐ Improved Confidence ☐ All of the Above

On a scale of 1–10, how important is orthodontic treatment for your child? 1 2 3 4 5 6 7 8 9 10

Do you have any concerns or fears about orthodontic treatment?

If we can address your concerns and provide a comfortable financial plan, how ready are you to begin treatment?

☐ Not ready ☐ Considering ☐ Ready ☐ Very ready

Patient Name: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

Unique Orthodontics

Effective Date: March 20, 2026

THIS NOTICE DESCRIBES HOW YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN ACCESS THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

OUR COMMITMENT TO YOUR PRIVACY

Unique Orthodontics is required by federal law (HIPAA) and California law (CMIA – Civil Code §56 et seq.) to maintain the privacy and security of your Protected Health Information ("PHI").

We are required to:

- Protect your health information
- Provide this Notice
- Follow the terms currently in effect
- Notify you of any breach involving your unsecured PHI

When laws differ, we follow the law that provides greater privacy protection.

HOW WE MAY USE AND DISCLOSE YOUR INFORMATION

We may use and disclose your PHI without your written authorization for:

Treatment

To provide, coordinate, and manage your orthodontic care, including referrals to specialists and labs.

Payment

To obtain payment, verify insurance benefits, submit claims, and collect outstanding balances.

Healthcare Operations

To operate our practice, including:

- Quality improvement and clinical review
- Staff training and credentialing
- Licensing and compliance
- Business administration

BUSINESS ASSOCIATES

We may share your PHI with third-party service providers ("Business Associates") who assist in operating our practice (e.g., billing companies, software providers, consultants). These parties are required by law to safeguard your information.

OTHER PERMITTED OR REQUIRED DISCLOSURES

We may disclose your PHI when required or permitted by law, including:

- Public health reporting
- Health oversight agencies (including the Dental Board of California)
- Legal proceedings (court orders, subpoenas)
- Law enforcement
- To prevent serious threats to health or safety
- Workers' compensation
- Coroners and medical examiners

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION

We will not use or disclose your PHI without your written authorization for:

- Marketing purposes
- Sale of PHI
- Use of identifiable photos/videos
- Disclosures not described in this Notice
- Sharing with non-care-related third parties
- Certain sensitive information protected under California law

You may revoke your authorization at any time in writing.

SOCIAL MEDIA, PHOTOGRAPHY & MARKETING

Unique Orthodontics may request written authorization to use:

- Photographs
- Videos
- Testimonials

for marketing purposes, including social media, website use, and promotional materials.

We will:

- Not use your identifiable information without written consent
- Allow you to refuse without affecting treatment
- Allow you to withdraw consent at any time

Important: Once information is shared publicly, it may no longer be protected under HIPAA.

TEXT MESSAGING, EMAIL & ELECTRONIC COMMUNICATIONS

We may contact you via:

- Text messages (SMS)
- Email
- Patient portal

for:

- Appointment reminders
- Treatment updates
- Billing notifications

By providing your contact information, you consent to these communications.

You have the right to:

- Opt out of text/email communications at any time
- Request alternative communication methods
- Request confidential communication channels

Note: Standard messaging/data rates may apply. Electronic communications may carry some level of risk despite reasonable safeguards.

RIGHT TO RESTRICT DISCLOSURE TO HEALTH PLANS (IMPORTANT)

If you pay out-of-pocket in full for a service, you have the right to request that we do not disclose that information to your health plan.
We are required to honor this request unless disclosure is otherwise required by law.

SPECIAL PROTECTIONS UNDER CALIFORNIA LAW

California law provides additional protections for certain types of information, including:

- Mental health records
- HIV/AIDS status
- Substance use disorder treatment
- Genetic information
- Minor-sensitive services

We will not disclose this information without proper authorization unless required by law.

MINOR PATIENTS

Parents or legal guardians generally have access to a minor's records.
However, under California law, minors may consent to certain services and have confidentiality rights.
When applicable:

- Access may be limited
- We will comply with California minor consent and confidentiality laws

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

You have the right to:

- Inspect and obtain copies of your records (within 15 business days for electronic copies under California law)
- Request amendments (corrections)
- Request restrictions on disclosures (may not always be granted)
- Request confidential communications
- Receive an accounting of disclosures
- Receive breach notification
- Receive a paper copy of this Notice

CONTACT / COMPLAINTS

Privacy Officer – Unique Orthodontics Maria Jabrayan 6688 N Cedar Avenue Fresno CA 93710 We will not retaliate against you.	You may also contact: U.S. Department of Health & Human Services (OCR) www.hhs.gov/ocr/privacy/hipaa/complaints 1-800-368-1019

OUR RESPONSIBILITIES

We must:

- Maintain privacy of your information
- Provide this Notice
- Follow its terms
- Notify you of breaches
- Obtain authorization when required

We reserve the right to update this Notice at any time. Updated versions will be available upon request.

ACKNOWLEDGMENT OF RECEIPT

I acknowledge that I have received or been offered a copy of this Notice of Privacy Practices.

Patient Name: _____ Signature: _____ Date: _____

Parent/Guardian (if minor): _____ Signature: _____ Date: _____