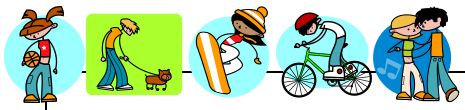
Welcome To UNIQUE ORTHODONTICS



PLEASE COMPLETE AND RETURN UPON CONSULTATION VISIT

Date

Email Address (parent/guardian)

Who is your DENTIST?

Last Visit:

Address: Phone:

Who may we THANK for referring you?

a. Please Tell Us About Your Child

1. First Name
2. Last Name
3. Age 4. DOB 5. M / F
6. School 7. Grade
8. Do you play sports?
9. Street Apt
10. City 11. State 12. Zip
13. Home Phone
14. Cell Phone
15. Work Phone (of parent/guardian)

b. Who is With the Child Today?

1. First Name
2. Last Name
3. What is Your Relationship to the Child?
4. Do You Have Legal Custody of this Child? Yes / No

c. Responsible Party Information

1. First Name
2. Last Name
3. Relationship to the Child?
4. Legal Custody of this Child? Yes / No

Residence

5. Street Apt
6. City 7. State 8. Zip

Mailing Address – if different

9. Street Apt
10. City 11. State 12. Zip
11. How Long at this Address?
12. Previous Address – if applicable
12. Street Apt
13. City 14. State 15. Zip
16. Home Phone
17. Cell Phone
18. Work Phone
19. SS#
20. Birth Date
21. Employer
22. Occupation
23. # of Years Employed

d. Parent Information- please fill out if different than section b or c, or for parent that is not present today

1. First Name
2. Last Name
3. What is the Relationship to the Child?
4. Does this person have Legal Custody of this Child?

Residence

5. Street Apt
6. City 7. State 8. Zip

Mailing Address

9. Street Apt
10. City 11. State 12. Zip

13How Long at this Address?

Previous Address – if applicable

14. Street Apt
15. City 16. State 17. Zip
18. Home Phone
19. Cell Phone
20. Work Phone
22. SS#
23. Birth Date
24. Employer
25. Occupation
26. # of Years Employed

e. Dental Insurance

1. Ins. Name	2. Group/Policy #	3. Ins. Address
4. Insured's Name		5. Relationship to Patient
6. Insured's DOB	7. Insured's SS#	8.Employer

Health History

Child's Dental History

Has the child ever had a serious/difficult problem associated with dental work?	O Yes O No
Has your child's jaw joint ever felt locked or as if it was sticking?	O Yes O No
Has your child ever had an injury to the jaw/teeth/chin/mouth?	O Yes O No
Has the child ever been evaluated by an Orthodontist?	O Yes O No
Does the child have any of the following habits?	
Thumb sucking/ finger sucking	O Yes O No
Lip sucking/ biting	O Yes O No
Nail biting	O Yes O No
Nursing bottle habits	O Yes O No
Is the child's water fluoridated?	O Yes O No
Is the child taking fluoridated supplements?	O Yes O No
Has the child ever had any pain or tenderness in the jaw/ joint (TMJ/TMD)?	**O Yes O No**
Does the child Brush his/her teeth daily?	O Yes O No
Floss his/her teeth daily?	O Yes O No
Please describe your child's dental health:	O Good O Fair O Poor

Child's Health History

Please describe the child's health:	O Good O Fair O Poor
Is the child currently under the care of a physician?	O Yes O No
Has the child ever taken PHEN-FEN or REDUX?	**O Yes O No**

Child's Physician	Phone	Last Visit

Please list all drugs the child is currently taking:

Has the child 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 the child has had below:

Are you aware of any allergies your child 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.**

Signature of Parent/Guardian Date

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

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

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