Welcome To Unique Dental Care

Date: _______________

Patient Information:

Patient Name: ____

Last First MI

Birthdate: _____/_____/______ Age: ________ SS#: ________________________

Address: ____ Apt: _________________

____

City State Zip

Home Phone: ________________ **Cell**: ________________ Work: _________________

E-mail:_______________________________________

Referred By: __________________________________

Employer: ___________________________________ How Long: _________________

Employer Address: ____

____

City State Zip

Occupation: ___________________________________

Status: ☐ Minor ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed

Spouse's Name: ________________________________

Do you have Children? ☐Yes ☐No How Many? ______________

Emergency Contact:

Name: ____

Relation: ____

Home Phone: __________________________________ _______________

Cell Phone: ____

Work Phone: _________________________________ ____ ____________

Primary Care Physician: ____

Doctor's Number: ____

Insurance Information:

Primary Insurance:

Co. Name: _________ ____

Insured's Name: ____

Relation: ____

Group Number: _________________ ___________________________________

Insured's ID: ___________________ __ ________ ________________________

Insured's Date of Birth: ____

Insured's Employer: _____________ ___________________________________

Secondary Insurance:

Co. Name: ____

Insured's Name: ____

Relation: ____

Group Number: ____

Insured's ID: ___________________ __ ________ _________________________

Insured's Date of Birth: ____

Dental Information:

Reason for your visit: ☐Exam ☐Emergency ☐Consultation

Are you in pain? ☐No ☐Yes How Long? ______________________________

Please indicate with a ☒ any of the following problems?

☐ Discomfort, clicking or popping in jaw	☐ Lost broken filling(s)	☐ Stained Teeth
☐ Red, swollen or bleeding gums	☐ Teeth grinding	☐ Locking jaw
☐ Sensitive tooth, teeth or gums	☐ Ringing in ears	☐ Bad breath
☐ Blisters/Sores in or around mouth	☐ Broken/Chipped tooth	☐ Pain

☐Other: ____

Do you require pre-medication? ☐Yes ☐No ☐Don't Know

Previous Dentist: __________________________________ (______) ________________

Name Phone #

Last Dental Exam: ______/______/______ Last Dental X-rays: ______/______/______

Times a day you brush? _______________ Times a week you floss: ________________

Type of tooth brush bristles you use? ☐Soft ☐Medium ☐Hard

How do you rate your smile? (worst) 1 2 3 4 5 6 7 8 9 10 (best)

Medical History:

What medications are you taking?

☐ Nerve pills	☐ Painkiller (including aspirin)
☐ Stimulants	☐ Blood Thinners
☐ Meds for Osteoporosis	☐ Insulin
☐ Tranquilizers	☐ Muscle relaxer

☐ Others, please list: ____

Have you taken: Bisphosphonates (ex. Aredia/Fosamax) ☐ Yes ☐No Phen-fen/Redux: ☐ Yes ☐No

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N	Heart attack/stroke	Y N	Thyroid Problems	Y N	Cancer/Tumors	Y N	Cosmetic surgery
Y N	Heart Surg./Pacemaker	Y N	Kidney Problems	Y N	Shingles	Y N	X-ray or Cobalt Treatment
Y N	Heart Murmur	Y N	Liver Problems	Y N	Hepatitis	Y N	Chemotherapy
Y N	Rheumatic Fever	Y N	Respiratory Problems	Y N	HIV+/AIDS/ARC	Y N	Asthma
Y N	Mitral Valve Prolapse	Y N	Sinus Problems	Y N	Arthritis/Rheumatism	Y N	Difficulty Breathing
Y N	Artificial Valves	Y N	Stomach Problems/Ulcers	Y N	Artificial Bones/Joints	Y N	Diabetes/Hypoglycemia
Y N	Heart Disease	Y N	Psychiatric Problems	Y N	Emphysema	Y N	Leukemia
Y N	Congenital Heart Defec	Y N	Venereal Disease	Y N	Fainting/Seizures/Epilepsy	Y N	Anemia
Y N	Chest Pains	Y N	Alcohol/Drug Abuse	Y N	Severe Frequent Headaches	Y N	High/Low Blood Pressure
Y N	Scarlet Fever	Y N	Tuberculosis TB	Y N	Frequent Neck Pain	Y N	Bleeding Problems
Y N	Nervousness	Y N	Jaw Problems TMJ/TMD	Y N	Back Problems	Y N	Glaucoma

Please list any other surgeries or medical conditions you have or ever had?

____

Are you allergic to any of the follow? ☐Latex ☐Penicillin/Amoxicillin ☐Tetracycline ☐Aspirin
☐Dental Anesthetics ☐Foods ☐Others? ______________

Do you use tobacco? ☐No ☐Yes

How used? ________________ How much? ______________ How long? _______________

Please rate your general health from 1-10 (10 being best): ___________

FOR WOMEN:

Are you taking Birth Control Pills ☐Yes ☐No How many children have you had? ___________

Are you pregnant? ☐No ☐Yes/How Long? ____________ Are you nursing? ☐Yes ☐No

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Patient/Parent Signature_________________________________ **Date**___________

Unique Dental Care
Office and Financial Policy

Patient Name________________________________ Date_________

FINANCIAL AGREEMENT:

Payment for services is expected at the time of each appointment. As a service to you, we will submit your charges to your insurance company for each visit. Insurance is only designated to cover a portion of customary fees, therefore, co-payments are due at the time of service as well as any balance insurance does not cover.

I understand I am responsible for payment to Unique Dental Care for the dental care provided to myself and/or my child/children.

ASSIGNMENT OF INSURANCE BENEFITS:

I authorize direct payment of dental insurance benefits to Unique Dental Care and its' associate doctors for treatment rendered.

CANCELLATION AND FAILURE TO ARRIVE:

We understand that circumstances do arise that can keep you from a dental appointment. **We will charge $50.00 per hour for the second missed appointment in our office when 48 hours notice has not been given.** Insurance companies do not pay for missed appointments.

I understand that an appointment time scheduled for me and/or my child is time set aside especially for individual dental attention and treatment. I understand the Cancellation Policy of Unique Dental Care and will attempt to give 48 hours notice if appointment must be rescheduled. I also understand that fees incurred on account for failed appointments must be paid prior to any further appointments are made.

X-RAYS:

Original x-rays are the property of Unique Dental Care. If you wish to have your x-rays duplicated, there will be a charge of $25.00 and 48 hours notice is required prior to picking up or mailing out per request.

By signing below, I acknowledge understanding of the Unique Dental Care Office and Financial Policies.

Patient/Parent Signature____________________________________ Date_________