

Welcome to Unique Dental Care

Date _____

Patient Information

1. Name _____ Date of Birth _____ S.S. # _____ Married/Single/Other

2. Address _____ Apt # _____

Town _____ State _____ Zip _____

*Phone # _____ *Cell # _____ *Other # _____

***Please provide us with at least two phone numbers.**

E-mail _____

3. Employer _____ Work Phone# _____ **OR**

Student At _____

EMERGENCY CONTACT: Name _____ Phone# _____

Responsible party : (if different from above)

Name _____ Address _____

Social Security # _____ Birth-date _____

How did you come to know about our office? (Please circle) Sign - Phone Book - TV - Radio or

Whom can we thank for this personal referral? _____

Dental Insurance Information This Does Not Apply To Me ____

1. Name of person carrying the Insurance _____

2. Insurance company Name _____

3. Insurance Group No. _____

4. ID or social security number of Insured _____

5. Insured Date of Birth _____

6. Insured Employed at _____

7. Do you have another dental insurance? _____

8. How can we help you today? _____

Dental History:

Former Dentist Name: _____ Date of last visit?(approx.) _____

Please circle all that apply:

- * Bad Breath
- * Bleeding gums
- * Blistering
- * Burning sensations
- * Chewing on one side
- * Tobacco use
- * Clicking or popping jaw
- * Dry mouth
- * Food collects between teeth
- * Fingernail biting
- * Gums swollen or tender
- * Grinding/Clenching teeth
- * Breathing through mouth
- * Lip or cheek biting
- * Pain around ear
- * Jaw pain or tiredness
- * Loose teeth or fillings
- * Mouth pain while brushing

Please answer the following questions?

1. Have you ever taken pre-medication (antibiotics) before dental visits? Y or N
2. Have you had any periodontal treatment (gum treatment) in the past? Y or N
3. Do you have sensitivity to hot, cold, sweets or when chewing? Y or N
4. How often do you brush? _____ floss? _____

Medical History:

Physician's Name: _____ Date of last visit? (approx.) _____

Please circle all that apply:

- * Aids/ HIV
- * Cortisone treatments
- * Heart Problems
- * Respiratory disease
- * Anemia
- * Circulatory problems
- * Hepatitis (type__)
- * Rheumatic fever
- * Arthritis
- * Congenital heart lesions
- * High blood pressure
- * Scarlet Fever
- * Artificial Heart Valves
- * Persistent Cough
- * Jaundice
- * Kidney Disease
- * Sinus Trouble
- * Artificial pins, plates, joints
- * Diabetic
- * Liver Disease
- * Skin rash
- * Asthma
- * Epilepsy
- * Low blood pressure
- * Swollen neck glands
- * Abnormal bleeding
- * Fainting/dizziness
- * Mitral Valve Prolapse
- * Thyroid problems
- * Blood Disease
- * Glaucoma
- * Pacemaker
- * Tumors or growths
- * Cancer
- * Headaches
- * Radiation treatment
- * Ulcer
- * Chemical Dependency
- * Heart Murmur
- * Venereal Disease
- * Weight Loss, unexplained

Women: Are you Pregnant — Nursing — Taking birth-control pills? (Circle any that apply)

Have you ever taken any group of drugs that are affiliated with Fen-phen? Yes or No
List Medications you are taking _____

Allergies: circle what applies: Latex Penicillin Codeine Sulfa Iodine
Local Anesthetic Aspirin Barbiturates (sleeping pills) OTHER _____

Patient _____ - ____/____/____

Doctor _____ - ____/____/____

Returning patients: Please review above and sign

Patient 1. _____ - ____/____/____
 Patient 2. _____ - ____/____/____
 Patient 3. _____ - ____/____/____

Doctor 1. _____ - ____/____/____
 Doctor 2. _____ - ____/____/____
 Doctor 3. _____ - ____/____/____

OFFICE POLICY of Unique Dental Care

FINANCIAL AGREEMENT:

Payment is due at time of service

Financial assistance is available, upon credit approval.

As a courtesy to you, we will submit all charges to the insurance company. Insurance is designated to cover a portion of the customary fee. Co-payments are collected at time of visit. (Please see our insurance policies.)

BALANCES LEFT ON ACCOUNT FOR OVER 60 DAYS: All parties will be responsible for the cost of collection, which may include but is not limited to any and all collection and legal fees.

Returned checks: There will be a \$25.00 fee.

Initial _____

CANCELLATION AND FAILURE TO ARRIVE:

We understand that circumstances do arise that can keep you from a dental appointment. Please, have the courtesy to give the office 48 hours notice. Please understand that we have reserved the doctors time for you and we will try to contact you at all phone numbers listed to confirm your appointment.

There will be a \$75.00 charge for all appointments missed or cancelled without 48 hr notice.

Initial _____

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 \$25.00 charge. A notice of 72 hours is required prior to picking up or mailing out.

PRIVACY NOTICE:

Privacy Act: I give Unique Dental Care permission to send reminder post cards to me through the U.S. Postal Service, and to leave messages via answering machine, voicemail, e-mail, or other family members.

By signing below, I understand the above listed policies, and assume responsibility for all services rendered

Patient/Parent/Guardian _____ Date _____