



## **ORTHODONTICS UNLIMITED**

**Specialist in Orthodontics and Dentofacial Orthopedics**

**Dear Patient,**

**On behalf of Dr. Kuruvadi and our entire team, I want to thank you for calling our office for an initial orthodontic evaluation.**

**Dr. Kuruvadi made the decision to base his orthodontic practice on three very simple principles: Quality Care, Personal Service and Reasonable fees. By always holding true to these principles Dr. Kuruvadi and his staff have been able to meet the orthodontic needs of area residents.**

**Dr. Kuruvadi has a terrific background and an uncommon curriculum: He is fluent in three languages including Spanish. He completed his post-graduate orthodontic program at Howard University, College of Dentistry - Department of Orthodontics in 1995 at the young age of 23. To this day, he continues to hold the record for being the youngest Orthodontist ever to graduate in the United States. During those years at school, Dr. Kuruvadi received numerous awards, including awards from the President, Governor and the Dean of Dental School for his excellence in education and for consistently ranking number one.**

**Although Dr. Kuruvadi practices only orthodontics, he has a vast amount of knowledge in other fields of Dentistry including Implantology, Periodontics, etc. He relates this knowledge to formulate the best orthodontic treatment available in the world for all his patients. Presently Dr. Kuruvadi practices his own "state of the art" Orthodontics at two locations: East County (El Cajon) and South County (Chula Vista).**

**At your appointment, each of us will do our very best to make sure that you are seen on time, to answer all of your questions and concerns, to recommend treatment that we would recommend to our own families, and to be absolutely flexible in our financial arrangements.**

**Please find enclosed a patient medical history form to be completed and bring them with you on the day of your appointment. If you have insurance that covers orthodontic treatment or orthodontic records (x-rays, photos, etc.), please bring that information with you as well. This initial exam appointment might take anywhere from 45 - 60 minutes.**

**We look forward to meeting you soon!**

**PATIENT INFORMATION FOR PATIENTS UNDER 18 YEARS OF AGE**

Date \_\_\_\_\_

Patient's name \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street City Zip

Nickname \_\_\_\_\_ Birthdate \_\_\_\_\_ Social Security # \_\_\_\_\_

School \_\_\_\_\_ Sports/Hobbies \_\_\_\_\_

Parent or guardian name \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION**

Name \_\_\_\_\_  
Last First Middle

Residence \_\_\_\_\_  
Street City Zip

Mailing Address \_\_\_\_\_  
Street City Zip

How long at this address? \_\_\_\_\_ Home phone \_\_\_\_\_ Work phone \_\_\_\_\_

Cell/other phone \_\_\_\_\_ Email address \_\_\_\_\_

Previous Address (If less than 3 years) \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. years employed \_\_\_\_\_

Spouse's Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ No. years employed \_\_\_\_\_

Social Security # \_\_\_\_\_ Birthdate \_\_\_\_\_ Work Phone \_\_\_\_\_

**DENTAL INSURANCE INFORMATION**

Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Phone No. \_\_\_\_\_

Do you have dual coverage? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes:

Insured's Name \_\_\_\_\_ Insured's Social Security # \_\_\_\_\_

Insurance Company \_\_\_\_\_ Group No. \_\_\_\_\_ Local No. \_\_\_\_\_

Insurance Co. Address \_\_\_\_\_ Phone No. \_\_\_\_\_

**EMERGENCY INFORMATION**

Name of nearest relative not living with you \_\_\_\_\_

Complete address \_\_\_\_\_  
Street City Zip

Phone \_\_\_\_\_

I understand that, where appropriate, credit bureau reports may be obtained.

Parent Signature \_\_\_\_\_

Updates (date & initial) \_\_\_\_\_

**MEDICAL HISTORY**

Physician \_\_\_\_\_ Date of Last Visit \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_  
Please circle Yes or No (If Yes, please fill in details)

- Yes No Is the patient taking any medication? \_\_\_\_\_
- Yes No Is the patient allergic to any medication? \_\_\_\_\_
- Yes No History of a major illness? \_\_\_\_\_
- Yes No Has the patient had any operations? \_\_\_\_\_
- Yes No Ever been involved in a serious accident? \_\_\_\_\_
- Yes No Have seen a physician in the last 12 months? Why? \_\_\_\_\_  
Female Patients only:
- Yes No Has menstruation started? \_\_\_\_\_
- Yes No Is the patient pregnant? \_\_\_\_\_

Circle any of the medical conditions below that the patient has had or currently has.

- |                              |                            |                          |                        |
|------------------------------|----------------------------|--------------------------|------------------------|
| Abnormal bleeding/Hemophilia | Diabetes                   | Hepatitis/Liver problems | Pneumonia              |
| Anemia                       | Dizziness                  | Herpes                   | Prolonged Bleeding     |
| Arthritis                    | Epilepsy                   | High Blood Pressure      | Radiation/Chemotherapy |
| Asthma or Hayfever           | Gastrointestinal Disorders | HIV / Aids               | Rheumatic Fever        |
| Bone Disorders               | Heart Problems             | Kidney problems          | Tuberculosis           |
| Congenital Heart Defect      | Heart Murmur               | Nervous Disorders        | Tumor or Cancer        |
- Are there any medical conditions we have not discussed that you feel we should be aware of? \_\_\_\_\_

**DENTAL HISTORY**

General Dentist \_\_\_\_\_ Date of last visit \_\_\_\_\_  
What concerns you most about your teeth? \_\_\_\_\_

- Yes No Is the patient presently in any dental pain? \_\_\_\_\_
- Yes No Ever experienced any unfavorable reaction to dentistry? \_\_\_\_\_
- Yes No Has the patient ever lost or chipped any teeth? \_\_\_\_\_
- Yes No Have there been any injuries to face, mouth, or teeth? \_\_\_\_\_
- Yes No Is any part of your mouth sensitive to temperature? Where? \_\_\_\_\_
- Yes No Is any part of your mouth sensitive to pressure? Where? \_\_\_\_\_
- Yes No Do gums bleed when brushing? \_\_\_\_\_
- Yes No Any type of thumb or tongue habit? \_\_\_\_\_
- Yes No Is the patient a mouth breather? \_\_\_\_\_
- Yes No Has the patient ever seen an orthodontist? If yes, who and when? \_\_\_\_\_
- Yes No What is the patient's attitude toward receiving orthodontic treatment? \_\_\_\_\_
- Yes No Has anyone in the family received orthodontic treatment? \_\_\_\_\_  
How did they feel about the result? \_\_\_\_\_
- Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning? \_\_\_\_\_
- Yes No Experience jaw clicking or popping? \_\_\_\_\_
- Yes No Aware of clenching or grinding teeth during the day? \_\_\_\_\_
- Yes No Experience "tension" headaches? \_\_\_\_\_
- Yes No Has the patient ever experienced chronic ringing in the ears? \_\_\_\_\_
- Yes No Does the patient need extra help with instructions? \_\_\_\_\_
- Yes No Is the patient sensitive or self-conscious about his/her teeth? \_\_\_\_\_
- Yes No Height of parents? Mom \_\_\_\_\_ Dad \_\_\_\_\_
- Yes No Are you aware that some appointments will be during school hours? \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_