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!

ADULT PATIENT INFORMATION

Date____________________

Patient's name____
Last First Middle

Residence ____
Street City Zip

Mailing Address____
Street City Zip

How long at this address?______ Home phone_________________________ Work phone ________________________

Previous Address (If less than 3 years)____

Cell Phone______________________ Birthdate_______________ Social Security # _____________________________

Email Address____________________ Marital Status: Single__ Married__ Widowed__ Separated__ Divorced___

Employer_____________________________________ Occupation____________________ No. years employed ______

Spouse's Name____ Relationship to Patient ____________________

Employer_____________________________________ Occupation____________________ No. years employed ______

Social Security # ____________________________Birthdate _________________ Work Phone___________________

Whom may we thank for referring you to our office?____

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.

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 Are you taking any medication? ______________________
Yes No Are you allergic to any medication? ______________________
Yes No Do you have a history of a major illness? ______________________
Yes No Have you had any operations? ______________________
Yes No Have you ever been involved in a serious accident? ______________________
Yes No Have you ever smoked or chewed tobacco? ______________________
Yes No Have seen a physician in the last 12 months? Why? ______________________
Female Patients only:
Yes No Are you pregnant? ______________________
Yes No Has menstruation started? ______________________

Circle any of the medical conditions below that you have had or currently have.

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 Are you presently in any dental pain? ______________________
Yes No Have you ever experienced any unfavorable reaction to dentistry? ______________________
Yes No Have your wisdom teeth been removed? ______________________
Yes No Have you 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 your gums bleed when you brush? ______________________
Yes No Do you have any type of thumb or tongue habit? ______________________
Yes No Are you a mouth breather? ______________________
Yes No Have you ever seen an orthodontist? If yes, who and when? ______________________
Yes No What is your attitude toward receiving orthodontic treatment? ______________________
Yes No Has anyone in your family received orthodontic treatment? ______________________
How did they feel about the result? ______________________
Yes No Do your teeth or jaws ever feel uncomfortable when you awake in the morning? ______________________
Yes No Are you aware of your jaw clicking or popping? ______________________
Yes No Are you aware of clenching your teeth during the day? ______________________
Yes No Have you ever been told that you grind your teeth? ______________________
Yes No Do you have "tension" headaches? ______________________
Yes No Have you ever experienced chronic ringing in your ears? ______________________
Yes No Are you aware that some appointments will be during work hours? ______________________

Signature: ______________________________ Date: ____________________