

# Dr. Tony Khara, DMD

*Specialist in Orthodontics for Adults and Children*

Initial Registration Form - Adult

*Welcome to our office! Please fill out this form completely so that we may serve you to the best of our ability.*

## **Patient Information**

**Today's Date** \_\_\_\_\_

Name: Mr. Mrs. Ms. \_\_\_\_\_

Date of Birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Contact Numbers: Home \_\_\_\_\_ Cell \_\_\_\_\_ Work \_\_\_\_\_

E-mail address \_\_\_\_\_

Your hobbies and interests \_\_\_\_\_

## **Family Information**

Spouse's Name \_\_\_\_\_

Work Phone Number \_\_\_\_\_ Cell Phone Number \_\_\_\_\_

Children's Names \_\_\_\_\_

Are any of your family members current patients in our office? \_\_\_\_\_

## **Insurance Information**

Do you have orthodontic dental insurance? Yes No Insurance Company \_\_\_\_\_

Name of subscriber \_\_\_\_\_ Relationship to patient \_\_\_\_\_

Subscriber's date of birth \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Subscriber's SSN \_\_\_\_\_

Subscriber's Employer \_\_\_\_\_ Group Number \_\_\_\_\_

## **Health History**

*For the safety of our female patients, if you are, or may be pregnant, please notify us before your appointment begins.  
X-ray exposure can be harmful during pregnancy.*

Is the patient in good health? Yes No \_\_\_\_\_

Please list any allergies or drug sensitivities: \_\_\_\_\_

Please circle any of the following conditions for which the patient has been treated:

AIDS/HIV      Arthritis      Diabetes      Epilepsy      Fainting/Dizziness

Heart Trouble      Hepatitis      Tuberculosis      Other: \_\_\_\_\_

Dentist's Name \_\_\_\_\_ City/State/Zip \_\_\_\_\_

Date of last visit \_\_\_\_\_ Reason for visit \_\_\_\_\_

Do you have any history of the following?

Removal of teeth.....	Yes	No	Root canal work.....	Yes	No
Sensitive teeth .....	Yes	No	Oral surgery.....	Yes	No
Sore, bleeding gums.....	Yes	No	Gum treatment .....	Yes	No

Other excessive treatment (please explain) \_\_\_\_\_

Is there any history of the following habits?

Thumbsucking	Yes	No	Grinding teeth	Yes : AM	or	PM	No
Fingersucking	Yes	No	Clinching teeth	Yes : AM	or	PM	No
Nail/Lip biting	Yes	No					

Do you breathe mainly through your mouth at night? ..... Yes No

Is there a clicking or popping of the lower jaw joint? ..... Yes No

Is there pain or ache of the lower jaw joint at any time? ..... Yes No

If yes, please explain \_\_\_\_\_

Does any member of the family have a similar arrangement of teeth or appearance of jaws? Yes No

What specific concerns/reasons made you consider orthodontic treatment?

- |   |   |
|---|---|
| <input type="checkbox"/> Crowding/spacing | <input type="checkbox"/> Overbite/underbite     |
| <input type="checkbox"/> TMJ discomfort   | <input type="checkbox"/> Dentist recommendation |
| <input type="checkbox"/> Appearance       | <input type="checkbox"/> Better speech          |

*I affirm that the information given is correct to the best of my knowledge. It will be held in the strictest of confidence and it is my responsibility to inform the office of any changes.*

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

**Who may we thank for referring you to our office?**

- |                                    |  |
|------------------------------------|--|
| <input type="checkbox"/> Dentist   | <input type="checkbox"/> Current patient _____ |
| <input type="checkbox"/> Insurance | <input type="checkbox"/> Newspaper _____       |
| <input type="checkbox"/> Internet  | <input type="checkbox"/> Other _____           |

