

Dr. Tony Khara, DMD

Specialist in Orthodontics for Adults and Children

Initial Registration Form - Child

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 _____

Patient's Name _____ Nickname _____

Date of Birth ____/____/____ Age _____ Gender _____ School _____

Address _____ City/State/Zip _____

Phone Number _____ E-mail address _____

Patient's Hobbies and Interests _____

Responsible Party

Father's Name _____ Work / Cell Phone Numbers _____

Mother's Name _____ Work / Cell Phone Numbers _____

Is patient living with both parents? Yes No If no, with whom is the patient living? _____

Person(s) responsible for the account _____

Do you have orthodontic dental insurance? Yes No Insurance Company _____

Name of insured _____ Relationship to patient _____

Date of Birth ____/____/____ Social Security Number _____

Employer _____ Group Number _____

Health History

For the safety of our female patients, if the patient is pregnant, 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: _____



Patient's Dentist _____ City/State/Zip _____

Date of last visit _____ Reason for visit _____

Does the patient 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 jaws	Yes:	AM or PM	No
Nail/Lip biting	Yes	No				

Does the patient breathe mainly through the 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

Has any member of the family had orthodontic treatment?..... Yes No

What specific concerns/reasons made you consider orthodontic treatment? (Please check all that applies)

- Crowding Spacing Other _____
- TMJ discomfort Overbite/ underbite
- Appearance Dentist Recommendation

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 _____

Relationship to Patient _____

Who may we thank for referring you to our office?

- Dentist Current patient _____ Internet
- Insurance Newspaper _____ Other _____