Welcome to the Office of Dr. Tony Khara!
Adult Registration Form

Please fill out this form completely so that we may be able to serve you to the best of our ability.

Date: _____

Name: _____ I like to be called: _____

Birth Date: _____ Age: _____ Gender: _____ SSN: _____

Address: _____ City/State/Zip: _____

Home phone: (_____) _____ - _____ Work/Cell Phone: (_____) _____-_____

Employer: _____ City/State/Zip: _____

Spouse's Name: _____ Spouse's SSN: _____

Spouse's Employer: _____ City/State/Zip: _____

OPTIONAL: E-mail address: _____

My hobbies and interests: _____

- What specific concerns do you have regarding your teeth and how they look and function?

  _____

- Who may we thank for referring you? _____

Your general dentist: _____ City/State/Zip:_____

Date of last visit: _____ Reason for visit:_____

Your Physician: _____ City/State/Zip: _____

Date of last visit: _____ Reason for visit: _____

Are you in good health? Yes No

Please circle any of the following for which you have been treated:

AIDS	Bloody cough	Fainting/Dizziness	Kidney Disease	Prolonged bleeding
Anemia	Diabetes	Heart Murmur	Nervous Disorder	Prolonged coughing
Arthiritis	Endocrine Problems	Heart Trouble	Night Sweats	Rheumatic Fever
Asthma	Epilepsy	Hepatitis	Pneumonia	Tuberculosis

List any allergies or drug sensitivities: _____

Drugs or medications that you are currently taking: _____

Any injuries to teeth, mouth, or jaw: _____

Do you require antibiotics before teeth cleaning or dental appointments? Yes No

Does your jaw ever click or get sore? Yes No

If yes, please answer the following:

Click? _____ When? _____

Sore? _____ When? (Morning, after eating, etc.) _____

Do you have trouble opening wide? Yes No How often? _____

Have you ever been informed of any missing or extra permanent teeth? _____

Please describe any previous orthodontic treatment: _____

Are there any other dental problems or oral habits (thumb sucking, etc.) that we should know about?

Do you have orthodontic insurance that covers adults? Yes No

Primary Subscriber's Name _____

SSN: _____-_____-_____ Date of birth: _____ Relation to patient: _____

Employed at _____ Work phone: _____

Primary Insurance Company: _____ Insurance phone: _____

Address: _____ City/State/Zip: _____

Group #: _____ Ortho Max: _____

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.

Insurance claims will be submitted by Dr. Tony Khara's office and all insurance payments will be made to Dr. Tony Khara. I understand that I will be responsible for all remaining orthodontic treatments costs not covered by insurance. I authorize the release of any information relating to this claim to the insurance carrier.

Signature: _____ Date _____