AZAR ORTHODONTICS
Since 1977

Child Registration Form

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About Your Child

Today's Date: _____/_____/_____

Child's Legal name: _____

Preferred name: _____

Birth Date: _____ Age: _____ **Circle one:** M F N/B

School: _____ Grade: _____

Hobbies/Sports: _____

Email: _____

Contact phone number: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Who is accompanying your child?

Name: _____ Relation: _____

Parent's marital status: _____

Do you have legal custody of this child? _____

Whom may we thank for referring you?

_____

Other family members seen by us: _____

_____

Has your child ever been evaluated or had orthodontic treatment before? **Y N**

Have there been any injuries to the face, mouth, teeth, or chin? **Y N**

Has your child been informed of any missing or extra permanent teeth? **Y N**

Has your child ever had any pain/tenderness in his/her jaw joint? (TMJ/TMD) **Y N**

Does your child brush his/her teeth daily? **Y N**

Floss his/her teeth daily? **Y N**

Does your child bite their finger nails? **Y N**

Is there a thumb/finger habit? **Y N**

Child's Dentist: _____

Date of last visit: _____

Please list all drugs your child is currently taking: _____

_____ _____ _____ _____

Patient is allergic to:

_____ _____ _____ _____

Has your child ever had any of the following medical problems?

Y N	Abnormal Bleeding	**Y N**	Hearing Impairments
Y N	Allergies to any Drugs	**Y N**	Heart Murmur
Y N	Allergic to Latex/Metals	**Y N**	Hemophilia
Y N	Allergic to Plastic	**Y N**	Hepatitis
Y N	Asthma	**Y N**	HIV+/AIDS
Y N	Cancer	**Y N**	Hospitalization
Y N	Congenital Heart Defects	**Y N**	Kidney/Liver Problems
Y N	Convulsions/Epilepsy	**Y N**	Operations
Y N	Diabetes	**Y N**	Rheumatic/Scarlet Fever
Y N	Handicap/Disabilities	**Y N**	Tuberculosis (TB)

Please describe any medical problems that your child has had:

_____

What are your main goals that you would like orthodontics to accomplish?

_____

_____

Please fill out reverse side as well

Please fill out both below if applicable

Circle One

Father Mother Step Parent Guardian

Name: _____

Birth Date: _____

Phone Number: _____

Email: _____

Employer: _____

Occupation: _____

Circle One

Father Mother Step Parent Guardian

Name: _____

Birth Date: _____

Phone Number: _____

Email: _____

Employer: _____

Occupation: _____

DENTAL INSURANCE (PRIMARY)

Insurance Company Name:

Insured's Name: _____ Relation: _____ Insured's DOB: ____/_____/____

SS #: _____ Insured's Employer: _____

Insurance Company: _____ ID: _____ Group #: _____

Insurance Company Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: (_____) _____-_____

DENTAL INSURANCE (SECONDARY)

Insurance Company Name:

Insured's Name: _____ Relation: _____ Insured's DOB: ____/_____/____

SS #: _____ Insured's Employer: _____

Insurance Company: _____ ID: _____ Group #: _____

Insurance Company Address: _____ City: _____

State: _____ Zip Code: _____ Phone Number: (___) _____-_____

The following person is authorized to have access to billing, appointment, and treatment information

Name: _____ Relation: _____

I understand that the information I have given today is correct to the best of my knowledge. I also understand this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I understand I am responsible for payment of services at the time they are rendered.