NICHOLAS P. AZAR, D.M.D., M.S.

AZAR ORTHODONTICS Since 1977

JOSEPH D. AZAR, D.D.S., M.S.

Adult Registration Form **Today's Date: _____**

PATIENT

Patients legal Name: _____ Preferred Name: _____

First Last

Birthdate: _____/_____/_____ Age: _____ Male: _____ Female: _____ N/B: _____

Cell Phone Number: (_____) _____-_____ & Email Address: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Current Employer: _____ Occupation: _____

Current Dentist: _____ Last Visit Date: _____

How did you hear about us? _____ Other Family members seen by us: _____

SPOUSE

Legal Name: _____ Birth date: _____

First Last

Cell Phone: (_____) _____-_____ Employer: _____

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.

Patient Signature: _____ Date: _____

Please fill out other side as well

GENERAL INFORMATION

What is your main orthodontic concern? _____

Has the patient ever been evaluated or had orthodontic treatment before? Yes No

Has there been any injuries to the face, mouth, teeth or chin? Yes No

List any musical instruments played: _____ _____ _____

Have adenoids or tonsils been removed? Yes No

Has the patient been informed of any missing or extra permanent teeth? Yes No

Has the patient ever had any pain/tenderness in the jaw joint (TMJ/TMD)? Yes No

Please list any medications patient is currently taking: _____ _____

HAVE YOU EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS OR HABITS?

Y N Any Allergies? (Metal or Latex?) _____ _____ _____ _____

Y N Any Underlying Medical Conditions? _____ _____ _____ _____

Y N Artificial Prothesis?	Y N Any operations?	Y N Any stays in a hospital?	Y N Handicaps/Disabilities?
Y N Thumb/Finger Sucking?	Y N Lip Sucking/Biting?	Y N Clenching/Grinding Teeth?	Y N Nursing bottle habits?
Y N Mouth Breather	Y N Speech Problems?	Y N Nail Biting?	Y N Tongue Thrust?

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: (_____) _____-_____