About Face
Orthodontics Dental Care

NEW PATIENT REGISTRATION FORM - ADULT

PATIENT INFORMATION

Patient Name: _____ Date: _____
Last First MI

❑ Male ❑ Female ❑ Married ❑ Single ❑ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Cell): _____

Preferred Appointment Times: ❑ Morning ❑ Afternoon ❑ Evening ❑ Any Time ❑ M ❑ T ❑ W ❑ Th ❑ F

Address: _____
Street Apartment #

_____
City State Zip

Email Address: _____

Name of Dentist: _____ Address: _____

Emergency Contact: _____ Relationship: _____

Phone Number: _____ In case of emergency, may we contact this person? ❑ Yes ❑ No

Whom may we thank for referring you to our practice? _____

Please tell us why you are seeking an evaluation and possible treatment:

Crowding _____ Overbite _____ Don't Like my Smile _____ Appearance _____

Better Function _____ Airway Assessment _____

My Dentist Found the Problem _____ I/We Don't See a Problem _____

Have you ever had any of the following? Please check all that apply:

Has the patient ever sucked their thumb? ❑ Yes ❑ No Until what age? _____

Does the patient have any speech problems? ❑ Yes ❑ No

Does the patient breath through their mouth? ❑ Day ❑ Night ❑ No

Has either parent had previous ortho treatment? ❑ Yes ❑ No

Does the patient play any musical (mouth) instruments? ❑ Yes ❑ No

Have you ever consulted an orthodontist or another dentist regarding the orthodontic or TMJ problem? ❑ Yes ❑ No

❑ AIDS/HIV
❑ Smoke/Tobacco Use
❑ Type:_____
❑ Anemia
❑ Arthritis
❑ Artificial Joints
❑ Asthma
❑ Blood Disease
❑ Cancer
❑ Diabetes
❑ Dizziness
❑ Epilepsy
❑ Excessive Bleeding
❑ Fainting
❑ Glaucoma
❑ Growths
❑ Hay Fever
❑ Head Injuries
❑ Heart Disease
❑ Heart Murmur
❑ Hepatitis
❑ High Blood Pressure
❑ Jaundice
❑ Kidney Disease
❑ Liver Disease
❑ Mental Disorders
❑ Nervous Disorders
❑ Pacemaker
❑ Pregnancy/Nursing
❑ Due Date:_____
❑ Radiation Treatment
❑ Respiratory Problems
❑ Rheumatic Fever
❑ Rheumatism
❑ Sinus Problems
❑ Stroke
❑ Tuberculosis
❑ Tumors
❑ Ulcers
❑ Venereal Disease
❑ Codeine Allergy
❑ Penicillin Allergy
❑ OTHER Allergies:
_____
_____

Have the tonsils or adenoids been removed? ❑ Yes ❑ No What age? _____

Does the patient have a tendency for colds? ❑ Yes ❑ No

Sore throats? ❑ Yes ❑ No Ear infections? ❑ Yes ❑ No

Has the patient ever had tubes in their ears? ❑ Yes ❑ No What age? _____

Are you now under the care of a physician? ❑ Yes ❑ No

If yes, please explain: _____

Name of Physician: _____ Phone: _____

Do you have any health problems that need further clarification? ❑ Yes ❑ No

If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ _____
Signature of Patient Date

Spouse or Responsible Party Information

The following is for: ❑ The Patient's Spouse ❑ The Person Responsible for Payment

Patient Name: _____ Date: _____
Last First MI

❑ Male ❑ Female ❑ Married ❑ Single ❑ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Cell): _____

Address: _____
Street Apartment #

_____
City State Zip

Employment Information

The following is for: ❑ The Patient' ❑ The Person Responsible for Payment

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ❑ Yes ❑ No
Last First MI

Insured's Birthdate: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip

Insured's Employer Name: _____

Address: _____
Street City State Zip

Patient's Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____ Is insured a patient? ❑ Yes ❑ No
Last First MI

Insured's Birthdate: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip

Insured's Employer Name: _____

Address: _____
Street City State Zip

Patient's Relationship to Insured: ❑ Self ❑ Spouse ❑ Child ❑ Other: _____

Insurance Plan Name and Address: _____

_____

Consent for Services

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to Dr. Allen Sanders' Office. I understand that I am financially responsible for any balance. I also authorize About Face Dental to release any information necessary to process my claims.

Patient Signature: _____ Date: _____