About Face
Orthodontics Dental Care

NEW PATIENT REGISTRATION FORM - CHILD

Parent / Guardian Name: Today's Date:

PATIENT INFORMATION

Patient's Last Name:	First:	Middle:	
Birthdate: / /	Age:	Preferred Name?:	Sex: ☐ M ☐ F
Street Address:		Home Phone #: ( )	
City:		State:	Zip:
School Name:		City:	Grade:
Mother's Name:	Phone #:	Email:	
Father's Name:	Phone #:	Email:	

We like to thank those who refer new patients! How did you hear about our office?

Other family members seen here, and their ages:

Name of person responsible for account:	Birthdate: / /	Relationship to Child?	Home Phone #: ( )
Email Address:	SSN:		Cell Phone # ( )
Occupation:	Employer:		Employer Phone #: ( )
Address (if different from child):		How would you prefer we contact you?	
I prefer appointment reminders to be:	Phone: ( )	Email:	

INSURANCE INFORMATION

(Please give your insurance card to our receptionist)

Is this patient covered by Insurance? ☐ Yes ☐ No	Name of primary insurance:			
Primary claim submission address:				
Primary subscriber's name:	Subscriber's SSN:	Birthdate:	Group #	Policy #
Patient's relationship to subscriber:	Name of Secondary Insurance (if applicable):			
Secondary subscriber's name:	Subscriber's SSN:	Birthdate:	Group #	Policy #
Secondary claim submission address:				

MEDICAL HISTORY

Family dentist: Phone #: ( )

Family Physician: Phone #: ( ) How is your child's overall health? Excellent / Good / Fair / Poor

Does your child have any allergies? Please list:

Is your child taking any medication? Please list:

Has your child ever had an allergic reaction to latex or a product containing latex? ❑ Yes ❑ No

Has your child ever been hospitalized? ❑ Yes ❑ No If yes:

Has your child had surgery? ❑ Yes ❑ No If yes:

Are there any behavioral or developmental problems? ❑ Yes ❑ No If yes:

How is your child doing in school?

Has your child ever had any of the following? Please check all that apply:

- ❑ Abnormal Bleeding
- ❑ AIDS/HIV
- ❑ Anemia
- ❑ Asthma
- ❑ Diabetes
- ❑ Epilepsy/Convulsions
- ❑ Hearing Impairment
- ❑ Heart Murmur
- ❑ Hemophilia
- ❑ ADD/ADHD
- ❑ Kidney Problems
- ❑ Liver Problems
- ❑ Sickle Cell Anemia
- ❑ Rheumatic Fever
- ❑ Speech Delay
- ❑ Autism Spectrum
- ❑ Fainting/Dizziness
- ❑ Tuberculosis
- ❑ Prosthetic Body Parts
- ❑ Heart Defect
- ❑ Tumors/Cancer

Does your child have any disease, condition or problem not listed that you think we should know about? ❑ Yes ❑ No

If any yes, please explain:

DENTAL HISTORY

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

Crowding Overbite Don't Like my Smile Appearance

Better Function Airway Assessment Teasing at School

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

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?

Has your child had previous orthodontic treatment? ❑ Yes ❑ No

Name: City When?

Does your child ever had any of the following? Please check all that apply:

- ❑ Grinding/Clenching
- ❑ Thumb/Finger/Lip Sucking
- ❑ Nursing/Bottle Habits
- ❑ Pacifier Sucking Habits
- ❑ Speech Problems
- ❑ Mouth Breathing
- ❑ Tongue Thrusting
- ❑ Chewing of Objects
- ❑ Nail Biting
- ❑ Snoring

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.

Parent/Guardian Signature: Date: