ALLURA
ORTHODONTICS

New Patient Form- CHILD

Patient's Name _____

Last First Middle

Address _____

Home Phone (_____) _____ Work Phone (_____) _____

Birth date _____ SS#_____

School _____ Grade _____

Siblings (Name and Age) _____

Patient's Dentist _____

How did you hear about our office? _____

RESPONSIBLE PARTY INFORMATION

Full Name _____

Last First Middle

Residence _____

Street City State Zip

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Birth date _____

Email address: _____

SS#_____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed ____

PRIMARY INSURANCE INFORMATION

Policy Holder's Name: _____

Last First Middle

Residence: _____

Street City State Zip

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Birth Date_____

SS#_____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Email address: _____

Insurance Co. _____ Group # _____ Local # _____

Insurance Co. Address _____Insurance Phone # _____

SECONDARY INSURANCE INFORMATION

Policy Holder's Name: _____

Last First Middle

Residence: _____

Street City State Zip

Home Phone (_____) _____ Work Phone (_____) _____

Cell Phone (_____) _____ Birth Date____ _____

SS#_____ Relationship to Patient _____

Employer _____ Occupation _____ No. Years Employed _____

Email address: _____

Insurance Co. _____ Group # _____ Local # _____

Insurance Co. Address _____Insurance Phone # _____

MEDICAL HISTORY

Is patient in good health? Yes_____ No_____

Does patient have any history of major illness? Yes_____ No_____

Has the patient ever been under the care of a physician for illness? Yes_____ No_____

Please List _____

Check any of the following for which the patient has been treated:

Diabetes ____ Tuberculosis ____ Endocrine Problems ____

Pneumonia ____ Anemia ____ Prolonged Bleeding ____

Heart Trouble ____ Epilepsy ____ Fainting & Dizziness ____

Rheumatic Fever ____ Asthma ____ Nervous Disorders ____

Bone Disorders ____ Kidneys ____ Liver ____

High Blood Pr. ____ Hepatitis ____ Venereal Disease ____

Blood Transfusion ____ Emotional Pr. ____ HIV Positive ____

Frequent Colds ____ Sore Throats ____ Ear Infections ____

List any drugs or medications now being taken. Give Reasons:

_____

_____

List any allergies or drug sensitivity: _____

Height_____ Weight _____ Has puberty/menstruation begun? Yes_____ No_____

Physician Name and Contact: _____

Is the Patient Pregnant? _____ If yes, what trimester? _____

DENTAL HISTORY

Does the patient need to be pre-medicated for dental treatment? Yes_____ No_____

Has there been any injury to the face, mouth or teeth? Yes_____ No_____

Has the patient ever sucked a thumb or fingers? Yes___ No____ If yes, until what age? _____

Does the patient have any speech problems? Yes_____ No_____

Is the patient a mouth breather? While awake? Yes____ No____ While asleep? Yes____ No____

List any musical instruments played: _____

Have you been informed of any missing or extra permanent teeth? Yes_____ No_____

Are there any medical, dental, or surgical problems not covered above? Yes_____ No_____

Has an orthodontist been consulted previously? Yes_____ No_____

Has either parent had orthodontic treatment? Yes_____ No_____

Reason for consultation _____

EMERGENCY CONTACT INFORMATION

Name of the Person: _____

Relationship to You: _____

Complete Address: _____

Phone: _____

I have read and understand the above questions. I have answered each one accurately and to the best of my knowledge. If there are any changes to the history and medical/dental record, I will so inform the staff at Allura Orthodontics.

Signature and Date: _____

Print Name: _____