Gaalaas Orthodontics

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Specialist in Orthodontics

Child Registration and Health History

PATIENT INFORMATION:

Patient's Name _____ Birth Date _____ Age ____ Gender _____

Street Address _____ Phone _____ Email _____

Mailing Address _____ City _____ State _____ Zip _____

In case of emergency, contact _____ Phone _____

Patient's Dentist _____ Referred by _____

Other family members treated at our office _____

Do you want to receive appointment reminders by text? Y N Phone number _____

PARENT INFORMATION: Marital Status of Parent(s): __Married __Separated __Divorced __Widowed __Single

Father's Name _____ Mother's Name _____

Occupation _____ Occupation _____

Employer _____ Employer _____

Work Phone _____ Cell Phone _____ Work Phone _____ Cell Phone _____

S.S.# _____ Birth Date _____ S.S.# _____ Birth Date _____

PERSON RESPONSIBLE FOR ACCOUNT:

Name _____ Relationship _____ Address _____

City _____ State ____ Zip _____ Phone _____ S.S.# _____

Do you have insurance coverage that includes orthodontic treatment for your family? Y N

Name of insurance company _____ Address _____

Name of policyholder _____ Policy / ID # _____ Group # _____

Reason for orthodontic exam _____

Date of patient's last dental exam _____ How often does patient brush? _____ How often does patient floss? _____

Has patient had:

Y N orthodontic treatment?
Y N oral surgery?
Y N a bite plane, splint or other oral appliance?
Y N gum treatment or their teeth ground/bite adjusted?
Y N clenching/grinding teeth, difficulty chewing or opening/closing mouth?
Y N clicking, popping, or other problems with the jaw?
Y N facial or TMJ pain (joint, ear, side of face)?
Y N difficulty breathing through nose or frequent mouth breathing?
Y N other airway concerns (e.g. asthma, enlarged tonsils/adenoids, sleep apnea)?
Y N snoring while sleeping?
Y N daytime tiredness/fatigue?
Y N hyperactivity?

Y N hepatitis?
Y N diabetes?
Y N herpes/cold sores?
Y N hypertension/high blood pressure?
Y N Has patient tested positive for HIV?
Y N Does patient take any premedication prior to dental visits?
Y N Does patient use any tobacco/nicotine products including e-cigs, vapes, etc.?
Y N Is patient taking any medication? Please name:

_____

Y N Is patient allergic to any medication? Please name:

_____

Y N Does patient have any other allergies? Please name:

_____

Y N Other health issues? _____

If yes to any of the above, please explain:

_____

_____

Signature _____ Date _____

(Parent or guardian if patient is under 18)

Thank You