Gaalaas Orthodontics

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Specialists in Orthodontics

Adult Registration and Health History

PATIENT INFORMATION:

Name ______________________ Birth Date ____________ Age _____ Male ____ Female ____

Street Address ______________________ Home Phone ____________ Cell Phone ____________

Mailing Address ______________________ City ____________ State ________ Zip ________

In case of emergency, contact ______________________ Phone ____________

Dentist ______________________ Referred by ______________________

Other family members treated at our office ______________________

Marital Status: __Married __Separated __Divorced __Widowed __Single S.S.# ____________

Occupation ______________________ Business Phone ______________________

Employer ______________________ Business Address ______________________

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

PERSON RESPONSIBLE FOR ACCOUNT:

Name ______________________ Relationship ____________ Address ______________________

City ____________ State _____ Zip ________ Phone ____________ S.S.# ____________

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

Name of insurance company ______________________ Policy / ID # ____________ Group # ____________

Name of policyholder ____________ Address ______________________ Birth Date ____________

Reason for orthodontic exam ______________________

Date of last dental exam ____________ How often do you brush? ____________ How often do you floss? ____________

Have you had:

Y N orthodontic treatment (braces)?
Y N oral surgery?
Y N a bite plane, splint or other oral appliance?
Y N gum treatment or your teeth ground or 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 or hyperactivity?

Y N hepatitis?
Y N diabetes?
Y N herpes/cold sores?
Y N hypertension/high blood pressure?
Y N Have you tested positive for HIV?
Y N Do you take any premedication prior to dental visits?
Y N Do you use any tobacco/nicotine products including e-cigs, vapes, etc.?
Y N Are you taking any medication? Please name:
____
Y N Are you allergic to any medication? Please name:
____
Y N Do you have any other allergies? Please name:
____
Y N Other health issues? ______________________

If yes to any of the above, please explain:

____

____

Signature ______________________ Date ______________________

Thank You