



Gaalaas Orthodontics

Specialists in Orthodontics

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Child Registration and Health History

PATIENT INFORMATION:

Patient's Name _____ Birth Date _____ Age ____ Male ____ Female ____
 Street Address _____ Home Phone _____ Cell Phone _____
 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 (braces)?	Y N hepatitis?
Y N oral surgery?	Y N diabetes?
Y N a bite plane, splint or other oral appliance?	Y N herpes/cold sores?
Y N gum treatment or their teeth ground or bite adjusted?	Y N hypertension/high blood pressure?
Y N clenching/grinding teeth, difficulty chewing or opening/closing mouth?	Y N Has patient tested positive for HIV?
Y N clicking, popping, or other problems with the jaw?	Y N Does patient take any premedication prior to dental visits?
Y N facial or TMJ pain (joint, ear, side of face)?	Y N Does patient use any tobacco/nicotine products including e-cigs, vapes, etc.?
Y N difficulty breathing through nose or frequent mouth breathing?	Y N Is patient taking any medication? Please name: _____
Y N other airway concerns (e.g. asthma, enlarged tonsils/adenoids, sleep apnea)?	Y N Is patient allergic to any medication? Please name: _____
Y N snoring while sleeping?	Y N Does patient have any other allergies? Please name: _____
Y N daytime tiredness/fatigue or hyperactivity?	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