Members American Association of Orthodontists®

Gaalaas Orthodontics

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Specialists in Orthodontics

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? ____ If yes: ❒ Text _____ ❒ Email Address _____

PARENT INFORMATION: Marital Status: __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? Yes_____ No_____

Name of policy holder _____ Policy / ID # _____ Group # _____

Name of insurance company _____ Address _____

Reason for orthodontic exam: _____

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

Has patient had:

YES	NO		YES	NO	
❒	❒	orthodontic treatment (braces)?	❒	❒	hepatitis?
❒	❒	oral surgery?	❒	❒	diabetes?
❒	❒	a bite plane or other appliance?	❒	❒	herpes?
❒	❒	gum treatment?			
❒	❒	their teeth ground or the bite adjusted?	❒	❒	Has patient tested positive for HIV?
❒	❒	clicking of the jaw?	❒	❒	Is patient taking any medication? Please name:
❒	❒	problems with the jaw?			_____
❒	❒	facial or TMJ pain (joint, ear, side of face)?	❒	❒	Is patient allergic to any medication? Please name:
❒	❒	difficulty in opening and closing?			_____
❒	❒	difficulty in chewing?	❒	❒	Does patient have any other allergies? Please name:
❒	❒	heart defect or heart murmur?			_____
❒	❒	rheumatic fever, scarlet fever?	❒	❒	Other health issues? _____
					_____

If yes to any of the above, please explain:

_____

_____

Signature _____ Date _____

(Parent or guardian if patient is under 18)

Thank You