Gaalaas Orthodontics

Peder A. Gaalaas, DDS • Sara A. Gaalaas, DDS, MS

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