Gaalaas Orthodontics

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

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 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 oral surgery?
Y N a bite plane, splint or other oral appliance?
Y N gum treatment or their 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 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:

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____

Signature ______________________ Date ______________

(Parent or guardian if patient is under 18)

Thank You