Dr. Gulland Orthodontist
www.DrGulland.com

Youth (18 yrs and younger)

WELCOME

My goal is to provide you with the best possible orthodontic experience. I consider it a privilege to work with you and I give you my word that I and my entire staff will do the very best for you. Please take a few moments to complete this form and bring it to your first visit.

Thank you,
Charles E. Gulland, D.M.D.

TELL US ABOUT YOU

Today's Date:_____

Child's Name:_____
First Middle Last

Nickname:_____

Birthdate:_____ Age:_____ ☐ Male ☐ Female

Home Address:_____

_____

How long have you lived at this address?_____

Home Phone:_____

School:_____ Grade:_____

Hobbies/Sports:_____

_____

Other Family Members seen by Dr. Gulland?_____

_____

Are there any other children in the family? ☐ Yes ☐ No

Names and ages:_____

_____

Whom may we thank for telling you about us?_____

_____

General dentist:_____

Last visit date:_____ ☐ X-rays taken?

ALTERNATE CONTACT INFORMATION

If we are unable to reach you list someone not living with you that we may contact.

His/Her name:_____

Relationship:_____

Work #:_____ Home #:_____

Who is accompanying you today?

Name:_____ Relationship: _____

Does this person have legal custody of you? ☐ Yes ☐ No

Are you adopted? ☐ Yes ☐ No

PARENT INFORMATION

Biological/Adopted Mother's Name: _____

Biological/Adopted Father's Name: _____

Biological/Adopted Parent's Marital Status:

☐ Married ☐ Single ☐ Widowed ☐ Separated ☐ Divorced

Biological/Adopted Mother's Information:

Name:_____ Birthday:_____

Address if different:_____

_____

Home Phone:_____ Work Phone:_____

Cell phone:_____ Email address:_____

Employer:_____

How long at job:_____ Job Title_____

Social Security #_____

If applicable, Stepfather's Name: _____

Biological/Adopted Father's Information:

Name:_____ Birthday:_____

Address if different:_____

_____

Home Phone:_____ Work Phone:_____

Cell phone:_____ Email address:_____

Employer:_____

How long at job:_____ Job Title_____

Social Security #_____

If applicable, Stepmother's Name: _____

Who does the child live with primarily? ☐ Mother ☐ Father

To whom may we speak regarding treatment and finance?

☐ Mother ☐ Father ☐ Stepmother ☐ Stepfather

Continued on back

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

MEDICAL HISTORY

Does your child have a personal physician? ☐ Yes ☐ No
Physician's name: _____
Phone #:_____ Date of last visit _____
Their physical health is: ☐ Good ☐ Fair ☐ Poor
Are they currently under the care of a physician? ☐ Yes ☐ No
Please explain: _____
Are they taking prescription/over the counter drugs? ☐ Yes ☐ No
Please list each one and the reason for taking:_____

_____

_____

Is there anything to discuss in private? ☐ Yes ☐ No
Do they smoke or use tobacco of any form? ☐ Yes ☐ No
Are their immunizations current? ☐ Yes ☐ No
For Girls: Has menstruation begun? ☐ Yes ☐ No
If yes, when: _____
Are they taking birth control pills? ☐ Yes ☐ No
Are they pregnant? ☐ Yes ☐ No
Week #: _____
Are they nursing? ☐ Yes ☐ No
For Boys: Has puberty begun? ☐ Yes ☐ No
Has their voice changed? ☐ Yes ☐ No
Patient's present height? _____ Expected height?_____
Father's height?_____ Mother's height? _____

Have they ever had any of the following diseases or medical problems? Check Y or N.

Abnormal bleeding	Y N	Heart surgery/pacemaker	Y N
Anemia	Y N	Hemophilia	Y N
Artificial bones/joints/valves	Y N	Hepatitis	Y N
Asthma	Y N	Arthritis	Y N
High/low blood pressure	Y N	Blood transfusion	Y N
HIV+/Aids	Y N	Cancer/Chemotherapy	Y N
Hospitalized for any reason	Y N	Congenital heart defect	Y N
Kidney problems	Y N	Diabetes	Y N
Tuberculosis	Y N	Mitral valve prolapse	Y N
Difficulty Breathing	Y N	Psychiatric problems	Y N
Drug/Alcohol abuse	Y N	Rheumatic fever	Y N
Emphysema	Y N	Glaucoma	Y N
Severe/Frequent headaches	Y N	Epilepsy/seizures/fainting	Y N
Shingles	Y N	Fever blisters/herpes	Y N
Sinus Problems	Y N	Heart attack/stroke	Y N
Ulcers/colitis	Y N	Heart murmur	Y N
Venereal disease	Y N	Radiation treatment	Y N

Please list any serious medical condition(s) they have ever had:

_____

Are they allergic to any of the following?

Aspirin	Y N	Dental anesthetics	Y N	Penicillin	Y N
Any metals/plastics	Y N	Erythromycin	Y N	Tetracycline	Y N
Codeine	Y N	Latex	Y N	Other	Y N
Nickle	Y N				

Please list any other drugs/materials that they are allergic to:

_____

DENTAL HISTORY

Does your child like their smile? ☐ Yes ☐ No
What are the main concerns that you/they would like orthodontics to address? _____

_____

Have they ever been evaluated for braces? ☐ Yes ☐ No
By whom?_____ When? _____
Their current dental health is: ☐ Good ☐ Fair ☐ Poor
Have they ever had a serious/difficult problem associated with any previous dental work? ☐ Yes ☐ No
How many times daily do they brush? _____
Do they floss their teeth daily? ☐ Yes ☐ No
Do their gums bleed? ☐ Yes ☐ No
Do they have or have they ever had any of the following habits?
☐ Lip sucking/biting ☐ Speech problems ☐ Mouth breather
☐ Thumb/finger sucking ☐ Nail biting ☐ Tongue thrust
☐ Clench/grind teeth
Do they generally breath through their mouth? ☐ Yes ☐ No
If yes: ☐ While awake ☐ While asleep
Have their adenoids or tonsils been removed? ☐ Yes ☐ No
Do they have any speech problems? _____
Do they still have any wisdom teeth? ☐ Unsure ☐ Yes ☐ No
Have they ever had an injury to their? ☐ Mouth ☐ Teeth ☐ Chin
Do they now or have they ever experienced pain/discomfort in their jaw joint (TMJ/TMD)? ☐ Yes ☐ No
Do they require antibiotics before dental work? ☐ Yes ☐ No

ADDITIONAL INFORMATION

Any additional information you can give us would be appreciated as the more we know about each other, the better we can help manage your treatment both at home and in the office.

_____

_____

_____

_____

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian named herein. Staff initials:____ Date:_____
Doctor's comments: _____

_____

_____

_____

Thank you for filling out this form completely

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services they may need. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

_____
Signature of Parent/Guardian Date