MEDICAL DENTAL HISTORY FORM PATIENTS UNDER 18

PATIENT

Date:_____

Patient's name:_____

Birthdate:_____ Sex: Male or Female (Circle)

Prefers to be called:_____ Hobbies,activities:_____

School:_____ Grade_____

Home or mailing address:_____

City,State and Zip code:_____

Home phone:_____ Cell phone:_____

PARENT/GUARDIAN

Father's full name:_____

Employment:_____ Email address:_____

Address (if different):_____

Home or cell number:_____ Work phone: (optional):_____

Mothers full name:_____

Employment:_____Email address:_____

Address (If different):_____

Home or cell number:_____Work phone:(optional)_____

Dentist

Patient's Dentist:_____ City, State:_____

Last seen:_____ Reason:_____

GENERAL INFORMATION

What concerns you about your child's teeth:_____

How does your child feel about orthodontic treatment:_____

Why did you select our office?:_____

Describe any previous orthodontic treatment:_____

Any other family member been treated in our office_____