TODAY'S DATE _____

MEDICAL DENTAL HISTORY FORM
PATIENTS UNDER 18 YEARS OF AGE

Delivering Amazing Smiles & Exceptional Service

CONFIDENTIAL

Please print in black or blue ink only

PATIENT NAME (First) _____ (Middle) _____ (Last) _____(Name Called) _____

Home Address _____

City _____ State _____ Zip _____Home Phone No. _____

Birthdate ____ / ____ / ____ Age _____ Sex M ❑ F ❑

Attends School At _____

Musical Instruments Played _____ Sports and/or Hobbies _____

No. of Brothers and Sisters _____Ages _____

Family Members Treated Here _____

Patient's Birth Weight _____ lbs. _____ oz. Patient's Present Weight _____ lbs._____ oz. Height _____ft._____ in.

Birth Father's Height _____ft. _____in. Birth Mother's Height _____ft. _____ in.

Who suggested that your child might need orthodontic treatment? _____

Why did you select our office? _____

Name of Patient's Dentist _____ Phone No. _____

Dentist Address _____ City _____ State _____ Zip _____

Date Last Seen ____ / ____ / ____ Reason _____

Name of Patient's Physician _____ Phone No. _____

Physician's Address _____ City _____State _____Zip _____

Date Last Seen ____ / ____ / ____ Reason _____

FATHER'S NAME: Mr. ❑ Dr. ❑ Rev ❑ _____

Address: _____City _____State _____ Zip _____

Home Phone No. _____Cell Phone No. _____E-Mail Address _____

Birth Date ____ / ____ / ____ Social Security No. (for insurance purposes only) _____ - _____ - _____

Employer _____ Occupation _____

MOTHER'S NAME: Mrs. ❑ Ms. ❑ Dr. ❑ Rev. ❑ _____

Address: _____City _____State _____ Zip _____

Home Phone No. _____Cell Phone No. _____E-Mail Address _____

Birth Date ____ / ____ / ____ Social Security No. (for insurance purposes only) _____ - _____ - _____

Employer _____ Occupation _____ Marital Status _____