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Patient Information

Patient Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Patient Phone Number \_\_\_\_\_ May we call this patient to schedule an appointment? Yes No

Referring Doctor \_\_\_\_\_ Last Visit \_\_\_\_\_

Doctor's Email \_\_\_\_\_ Office Phone Number \_\_\_\_\_

Primary Concerns \_\_\_\_\_

Medical Information

Concerns:	
Class <b>II</b>	Crossbite
Class <b>III</b>	Crowding
Deep Bite	TMD
Open Bite	Impacted Teeth
Excessive Overjet	Missing Teeth
Other: _____	

Specific Dental Problems:
Oral Surgery
Periodontal
Endodontic
Implants

Radiographs Available:
Periapicals
Panoramic
Bite Wing
Full Mouth Series

Addition Information: