

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 II	Crossbite
Class III	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: